

Maricopa County Coordinated Community Health Needs Assessment 2020-2023

Maricopa County Public Health
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HEALTH IMPROVEMENT PARTNERSHIP OF MARICOPA COUNTY

SYNAPSE
A Platform for Community Health Partnership

Foreword

I am truly pleased to present the results of our third-ever community health assessment (CHA 3.0) representing nearly two years of extensive effort by staff of the Maricopa County Department of Public Health and our many hospital, healthcare, and community partners. I am grateful for the thoughtful work and generous support, and hours of outreach and engagement that made this possible.

This new assessment was undertaken with a root-causes approach with the intent that we all (not just our department, but rather the entire community) can make a dent in the causes of many of the ills facing our community. The assessment process collected data from community perspectives, partner insights, and staff input to whittle down our priorities to a few strategic issues that drive many of the health problems affecting Maricopa County residents.

With that in mind, after much analysis and debate, the three priority strategic issues that came out of the assessment this time are:

- Access to Care
- Access to Healthy Food
- Early Childhood Development

These are big topics that contribute to several other downstream issues and health outcomes to be addressed in our next Community Health Improvement Plan (CHIP) that will soon follow. The role this report will play in the development of that plan is described much more eloquently by the Preface than I ever could, so please read on. We hope that all our partners find this a useful guide as we move forward together in our journey toward creating a healthier Maricopa County.

Sincerely,

Marcy Flanagan, DBA, MPH, MA
Director, Maricopa County Department of Public Health

Acknowledgements

A work of this magnitude can be accomplished only through a collaborative effort involving groups and individuals too numerous to name. Here we recognize many of our effort's key leaders, supporters, and contributors, but we also wish to thank the many others whose participation and assistance enriched the process and made this final product possible.

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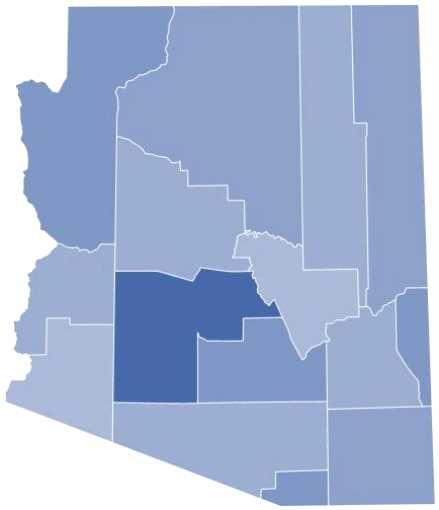
Executive Summary



This community health assessment provides an overall picture of health and well-being in Maricopa County. Maricopa County, Arizona, is the fastest growing county in the United States, with more than 4.4 million residents at present.[1] Maricopa County encompasses over 9,200 square miles, roughly the size of the state of Vermont, composed of a mix of urban, suburban, and rural areas including the whole or parts of five sovereign American Indian Reservations.

Every three to five years, Maricopa County Department of Public Health, in collaboration with health care and community partners, conducts a Community Health Assessment to develop a deeper understanding from residents about issues that relate to quality of life, availability of services, physical and mental health, and more. This goes beyond individual health to look at what is affecting the community overall, what health issues are affecting some communities more than others, and what other factors contribute to those issues.

2020-2023 Coordinated Community Health Needs Assessment

The 2019 Coordinated Community Health Needs Assessment (CCHNA) is a continuation of the 2017-2018 community health assessment, planning, and implementation cycle. This report will outline the work completed from 2018 through 2020 and end with an introduction to the new CHA cycle which will begin November 2020. In response to the COVID-19 pandemic and as a supplemental part of this cycle, MCDPH will be collecting a combination of qualitative and quantitative data that reflects the experiences of both community stakeholders and individuals as it relates to COVID-19 in addition to other day to day health impacts. This is an initial effort to capture some of the emerging needs in the community as well as to forecast how those needs may evolve and impact this cycle's data collection outcomes. Due to the urgent and widespread needs affecting all sectors of the community, this community health assessment supplemental survey is intended to provide initial information to describe the scope of crisis in our community and to support the different responses that will be required in addressing emerging, evolving needs.

Health Priorities

From all the issues identified in the assessments, only a small number can be selected to provide focal points for coordinated health improvement efforts. Through a multi-stage process of review and prioritization using several quality improvements tools, three priority strategic issues were chosen. These priorities will continue to be the focus of this community health improvement plan (CHIP) until 2023:

1

Access to Care: Appropriate access to care means that everyone receives the services and supports they need to maintain optimal health and wellbeing throughout their lifetimes. This encompasses both medical and non-medical care that effectively prevents, treats, and/or minimizes the effects of health problems and supports quality of life. This requires that care services be obtainable, accessible, and affordable to all, and be designed to ensure that individuals understand how to navigate efficiently through the care delivery system to meet their needs. Such care must also impart the best possible health outcomes and be delivered through a respectful relationship between the caregiver and recipient that is based on mutual trust and understanding.

2

Access to Healthy Food: Appropriate access to healthy food means that all individuals can easily obtain high quality, fresh, affordable, and nutritious food. In both urban and rural settings, regular access to healthy food retailers and other healthy food outlets that offer fruits, vegetables, and other staples at affordable prices contribute to a more equitable food environment. Such a food environment reduces food insecurity and hunger, supports nutritious diets that lead to healthier lifestyles, and provides opportunities for thriving local economies. Special attention must be paid to ensure that culturally appropriate healthy food options are available to all communities.

3

Early Childhood Development: Appropriate early childhood development means that all young children grow up in safe and supportive environments and receive the nurturing care and interaction needed to promote their physical, mental, and emotional growth and resilience that enables them to become healthy, happy, and productive in later life. This requires that children be protected from harm, neglect, and other undue adverse experiences. It also means that families, parents, and other caregivers must have the physical, social, and economic means to provide for their children's needs as well as their own. Adequate support, education, and other services must also be available for children and families to address any problems during early childhood when these interventions are most likely to be effective.

Next Steps

Community Health Improvement Planning and Action

Looking forward, the HIPMC and Synapse coalitions will continue to use information from the CCHNA to initiate the development of a community health improvement plan (CHIP). The CHIP began with the creation of goal statements that would make substantial strides in addressing each of the three priority strategic issues. Potential strategies for approaching each of those desired goals are also identified. The CHIP will then be drafted in detail by adding specific objectives, timelines, work plans, and assignments of responsibility for the tasks required to meet those objectives.

The CHIP work plan will be implemented over a five-year period, from 2018 through 2023. Though the CHIP framework was created in early 2018, the work plan will not be a static document. During its implementation, activities will be continually evaluated so that our results can be used to adjust and improve our course as necessary.

The Continuous Cycle of Assessment, Planning, and Implementation

With this report, Maricopa County's community health assessment and improvement planning processes accelerate from its past 5-year cycle to a more ambitious and responsive 3-year cycle. Thus, the next CCHNA process for Maricopa County will commence in 2021 and be completed in early 2023 to support the development of the next CHIP that will be implemented in 2023 through 2026. The research conducted to develop the CCHNA is supported by HIPMC and Synapse coalitions. Health Improvement Plan of Maricopa County (HIPMC) is a collaboration between private organizations, public entities, and the Maricopa County Department of Public Health (MCDPH) to address priority health issues through a community health improvement plan (CHIP). Synapse is a partnership between multiple non-profit healthcare providers to collect data that informs investment into the most pressing needs of our community. The vision is to participate in a collaborative approach that identifies community needs, assets, resources, and strategies towards assuring better health and health equity for all Maricopa County residents.

Introduction

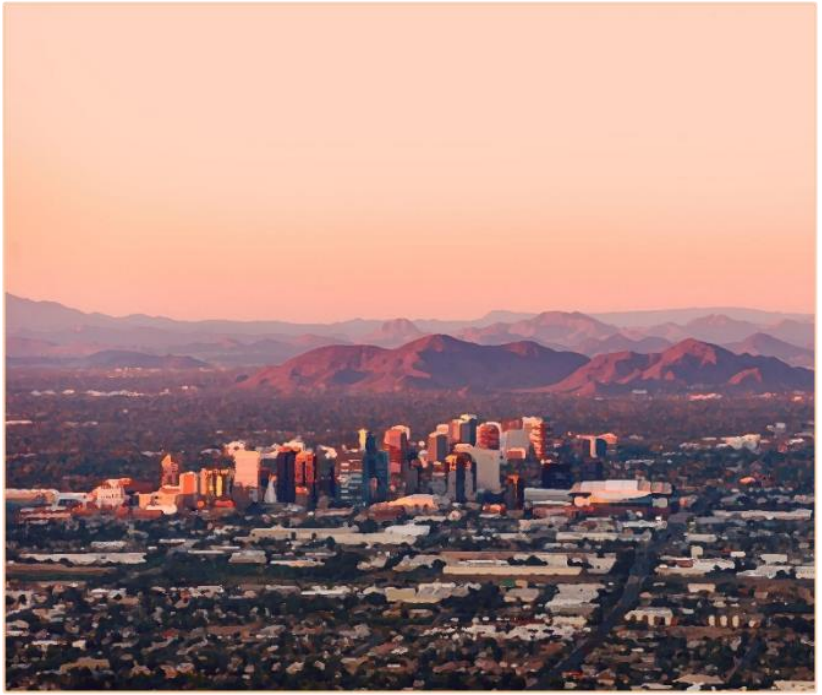
Maricopa County

Maricopa County, Arizona, is the fastest growing county in the United States with a population of 4.4 million.[1] Home to nine out of ten of the state's largest cities, including Phoenix (the fifth largest city in the U.S.), Maricopa County serves as the state's primary metropolitan, political, and economic center.

Community Health Assessment

Community health assessment (CHA) is one of the core functions of public health. CHAs have long been used as a tool by hospitals, public health departments and other social service agencies to identify key community health concerns. A CHA is a systematic process involving the community to identify and analyze community health needs and assets, prioritize those needs, and then implement a plan to address significant unmet needs. A community health assessment process can focus your organization's efforts around community health improvement and provide structure for addressing the determinants of health and illness in your community. In Maricopa County, the primary responsibility for community health assessment falls to the Maricopa County Department of Public Health (MCDPH), a PHAB-accredited agency.

Past Community Health Assessment for Maricopa County



Maricopa County's first community health assessment (CHA 1.0) was completed in 2012. The assessment was conducted by MCDPH and the Arizona Department of Health Services. The effort was led by an advisory board and a community advisory team that engaged community leaders, local agencies, and other stakeholders in a broader and more inclusive collaborative effort. The Community Health Assessment 1.0 report may be viewed here: www.HIPMC.org.

From those advisory groups, the Health Improvement Partnership of Maricopa County (HIPMC) was born during the creation of the subsequent community health improvement plan (CHIP) and its execution from 2012 through 2017. The HIPMC is a member-driven collaborative with participation from organizations in the public health system and non-traditional sectors. The 2012-17 CHIP was created collaboratively by MCDPH and members of the HIPMC. The CHIP identified targets for improving the quality of life for all Maricopa County residents, particularly the most vulnerable in our community, by reducing preventable illness and death. The CHIP used a strategy framework that aligned prevention strategies along four community sectors: Where We Live (Community), Where We Work (Worksites), Where We Learn (Education), and Where We Receive Care (Healthcare).

Targeted health priorities in the 2012-2017 CHIP were Diabetes, Access to Healthcare, Cardiovascular Disease, Lung Cancer and Obesity. CHIP objectives were collected by MCDPH from agencies participating in the HIPMC. Initiatives undertaken by HIPMC members were placed into the strategy framework to create the Maricopa County CHIP Work Plan. The work plan has been a dynamic document updated on a quarterly basis and progress on objectives has been reported annually (see: www.HIPMC.org).

Current Community Health Needs Assessment for Maricopa County

The 2020-2023 Coordinated Community Health Needs Assessment (CCHNA) is a continuation of the community health assessment, planning, and implementation cycle that began with the previous cycle in 2017 and will focus on the current health priorities, access to care, access to healthy food, and early childhood development. Because the focus will continue to be on these priorities, A new cycle will begin with a new assessment December 2020 which will include supplemental data collected on COVID-19.

Like the previous assessment, this CCHNA is the product of an 18-month-long collaborative effort undertaken by a variety of community health stakeholders. These include the member organizations of the Health Improvement Partnership of Maricopa County (HIPMC) and the Maricopa County Synapse coalition, with MCDPH participating both as a member organization in both groups, and as the lead agency that facilitated the overall CCHNA process.

The Patient Protection and Affordable Care Act (ACA) has requirements that nonprofit hospitals must satisfy to maintain their tax-exempt status under section 501(c) (3) of the Internal Revenue Code. One such requirement added by the ACA, Section 501(r) of the Code, requires nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) to address the identified needs for the community at least once every three years. The ACA requirements are mirrored in the Public Health Accreditation Board's (PHAB) standard mandating that health departments participate in or conduct a community health assessment every three to five years. Federally funded community health centers must also ensure their target communities are of high need. The similar requirements from IRS, PHAB, and the federally funded health center requirements put forth by the United States Department of Health and Human Services provide an opportunity to catalyze stronger collaboration and better shared measurement systems among hospitals, health centers, and health departments. Additionally, limited resources for comprehensive health assessments and the move toward new population health models have created the need for an organized, collaborative public-private approach for conducting assessments. As a result, Banner Health, Adelante Healthcare, Dignity Health, Mayo Clinic Hospital, Native Health, and Phoenix Children's Hospital have joined forces with HIPMC and Maricopa County Department of Public Health to identify the communities' strengths and greatest needs in a coordinated community health needs assessment.

Our Approach

Mobilizing for Action through Partnerships and Planning

Mobilizing for Action through Planning and Partnerships (MAPP) is a community-driven strategic planning process for improving community health. Facilitated by public health leaders, this framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. MAPP is intended for improvement planning as it is an interactive process that can improve the efficiency, effectiveness, and ultimately the performance of local public health systems. MAPPP is provided by the National Association of County and City Health Officials (NACCHO).[2]

MAPP provides a framework that is amenable to PHAB accreditation standards that set a number of minimum criteria for the nature, content, and performance of a community health assessment by a local health department. MAPP offers a balanced approach with aspects of both assets-based and needs-based assessment. Moreover, it includes methods to help communities organize their efforts, assess their current status, and take action to produce measurable improvements. As the figure on the next page suggests, MAPP serves as our "community roadmap to health."

The MAPP process consists of six sequential steps, or phases, each including a series of practical activities that provide the foundation for the next phase.[2] For convenience of presentation in this report, the six phases of MAPP are grouped into two stages. The community health assessment stage includes the first four phases, while the last two phases comprise the community health improvement stage. This CCHNA report covers the four phases included in the community health assessment stage. The final two phases will be addressed in a forthcoming Community Health Improvement Plan (CHIP) report.

Phase 1- Organizing and Engaging Partners

Careful planning and organization are prerequisites for any successful journey. Thanks to the partnerships and collaborative infrastructure that were built for the previous community health assessment and improvement efforts, the 2019 (CCHNA) began with a significant head start advantage.

Partnerships and Collaboration

Good community-oriented public health practice is rooted in principles of broad inclusion and genuine community engagement. As mentioned previously, the 2019 CCHNA is the product of an 18-month-long collaborative effort undertaken by a variety of community health stakeholders, primarily the member organizations of the Health Improvement Partnership of Maricopa County (HIPMC) and the Synapse collaborative.

Health Improvement Partnership of Maricopa County (HIPMC)

When the Maricopa County Department of Public Health (MCDPH) and the state health department initiated the first community health assessment for Maricopa County in 2011, two advisory bodies were formed to provide leadership and broad community representation for the effort. One was a small advisory board to lead the effort, and the other was a larger community advisory team. At the time, these were necessary steps to ensure that the assessment process would be a truly collaborative effort among a significant number of community agencies and other stakeholders.

When the community health assessment was completed in 2012, it was time to establish a community health improvement plan (CHIP) that would set challenging goals for improvement and provide a plan of action to achieve those goals. Even more daunting would be the prospect of implementing that action plan. To be effective, that plan and its implementation would have to be a coordinated effort that could be sustained for several years, suggesting the need for a more formal and consistent partnership among interested stakeholders. Thus, the Health Improvement Partnership of Maricopa County (HIPMC) was born from the advisory groups that had supported the community health assessment.

The HIPMC brings together partner agencies and advocacy organizations and provides a stable infrastructure to share ideas and resources, identify gaps and barriers to existing services, and engage in thoughtful planning to achieve a shared vision. Professionals from public and private organizations, as well as community residents, hear about the HIPMC through quarterly meetings, MCDPH collaborative projects, community networking, and communication outreach activities, including a website, a HIPMC Facebook and Twitter page, and a monthly HIPMC e-newsletter.

MCDPH is both a member and the convener of the HIPMC. MCDPH also serves as the partnership's "backbone" by providing infrastructure, dedicated staff, and other resources to support and sustain the partnership. Infrastructure developed for the HIPMC includes a public portal for communication and dissemination of all related materials and activities. MCDPH funded the build-out of the Maricopa County-specific pages of the Arizona Health Matters website for all HIPMC materials (see www.MaricopaHealthMatters.org). The website houses a virtual "toolbox" as a resource for evidence-based practices, grant opportunities, communication tools, and related reports, data, and health indicators. The site houses all the documents of the 2012 CHA and CHIP and provides a venue for inclusion of new partners.

At present, the HIPMC is a partnership of more than 100 public and private organizations representing 50 different community sectors (a complete list of members and their sector representation is provided in Appendix A). It is led by a 12-person Steering Committee composed of representatives from each of the major sectors of the HIPMC's membership. Members come from traditional public health services (e.g., healthcare, social services, education, etc.) and non-traditional sectors (e.g., housing, transportation, military, and refugee services, etc.). Candidates for the Steering Committee are nominated by members of the HIPMC and undergo a thorough review and selection process. The Steering Committee is governed by formal bylaws established by its inaugural members in 2015.

Synapse Collaborative

In addition to public health departments and healthcare systems, a number of other community agencies conduct similar community-level assessments for a variety of reasons. For instance, nonprofit hospitals are required by federal regulations to conduct a community health needs assessment (CHNA) periodically to maintain their federal tax-exempt status. Federally qualified health centers (FQHCs) are required to document community health needs as part of their renewal of federal grant funding. These agencies use that information not only to respond to their particular regulatory requirements, but more importantly to better direct their current operations, identify gaps in services, anticipate related opportunities, and develop new services to better meet the needs of their clients, customers, and community.

In 2014, MCDPH and a core group of HIPMC-member nonprofit hospitals and federally qualified community health centers recognized their shared needs as an opportunity to formalize a joint effort for coordinated community health assessment and health improvement planning. Synapse is a group of seven of the county's nonprofit hospital systems and federally qualified health centers (FQHCs) that are now working together to align their individual agencies' assessments and action plans, both with each other and with the broader such efforts of MCDPH and the HIPMC. While Synapse member agencies were already part of the HIPMC, the consolidation of their formerly

parallel, independent efforts is a significant leap forward in the coordinated assessment of Maricopa County's health. The modified title of "*coordinated* community health *needs* assessment" used for the present report is to reflect the substantial contribution of Synapse to the larger assessment effort in Maricopa County.

As with HIPMC, MCDPH is both a member and the convener of Synapse. MCDPH provides the organizational infrastructure for Synapse with dedicated staff and other resources supported by its contracts with each Synapse member. The Venn diagram below depicts the organizational relationships between MCDPH, HIPMC, and Synapse. MCDPH overlaps with HIPMC as a member of HIPMC and its facilitator and infrastructure provider. A representative of MCDPH also holds a seat on the HIPMC Steering Committee, *ex officio*.

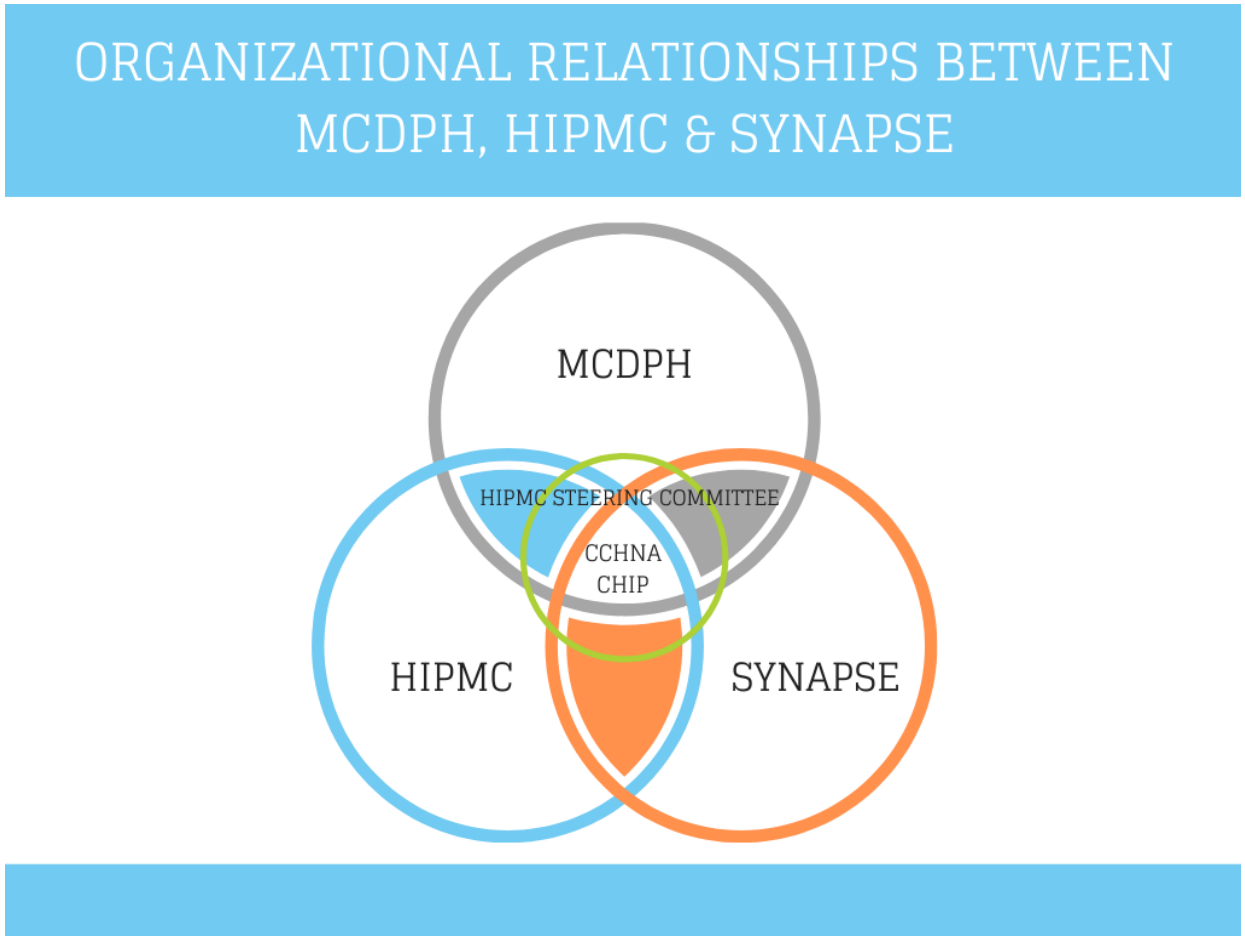
Similarly, MCDPH's contractual arrangements with the Synapse members define its role as a member of Synapse and as its paid infrastructure provider, producing the overlap between MCDPH and Synapse. In a sense, the relationship between Synapse and HIPMC could be depicted as fully overlapping since each member of Synapse is also a member of HIPMC. However, as an independently functioning collaborative in its own right, the collective identity of Synapse is different than that of its individual members' association with HIPMC. As a unique entity, Synapse is depicted as partly overlapping with HIPMC, both because of the aforementioned relationships of its individual members to HIPMC, and by virtue of the seat Synapse holds on HIPMC's Steering Committee, ex *officio*.

Coordinated Assessment

While Synapse members are also members of HIPMC where they participate in the overall MAPP process and support the CCHNA and CHIP, their roles in Synapse differ slightly in their focus on the production of their individual CHNA reports. The support of Synapse enhances the scope of the CCHNA, and each hospital/FQHC will use findings from the CCHNA to inform their work.

Collective Impact

The CCHNA and CHIP are the shared products of all three entities and will constitute the guiding documents for their joint actions. A long-term goal is to align the priority issues of the Synapse members' CHNAs with those of the CCHNA (see the *Phase 4 – Identifying Strategic Issues* chapter), as well as to align their respective health improvement interventions with the CHIP. Presently, the Synapse partners are working toward aligning the timelines for all CHNAs to be on the same three-year cycle, then to align that with CCHNA/CHIP 3-year cycle.

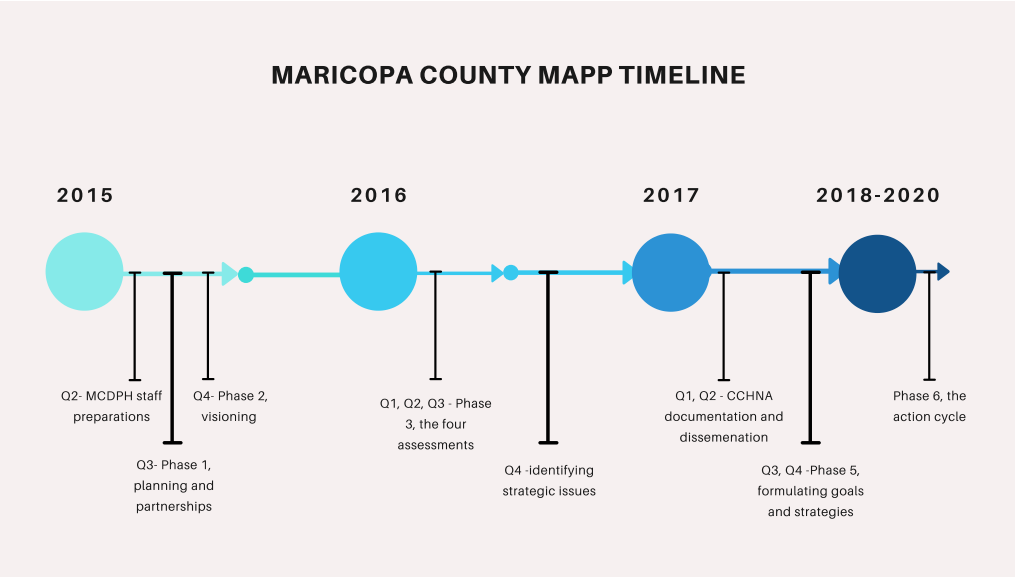


Quality Improvement

HIPMC has integrated the "Community of Solutions" model promulgated as part of the SCALE (Spreading Community Accelerators through Learning and Evaluation) initiative of the Institute for Healthcare Improvement.[3] The Steering Committee and HIPMC membership have embraced the Model's quality improvement approach for both the CCHNA and CHIP frameworks and evaluation including the use of multiple QI tools such as driver diagrams, prioritization matrices, and rapid feedback forms. The SCALE Community of Solutions is a model of community change based in reflective practice, collaboration, design thinking, improvement science, equity, and generative sustainability. It is intended to help communities develop a set of leadership skills and capacities to produce "a set of behaviors, processes, and systems that, over time, promise to lead to sustainable, growing improvements in health, well-being, and equity (Culture of Health Outcomes)".[3]

Planning and Preparation for MAPP

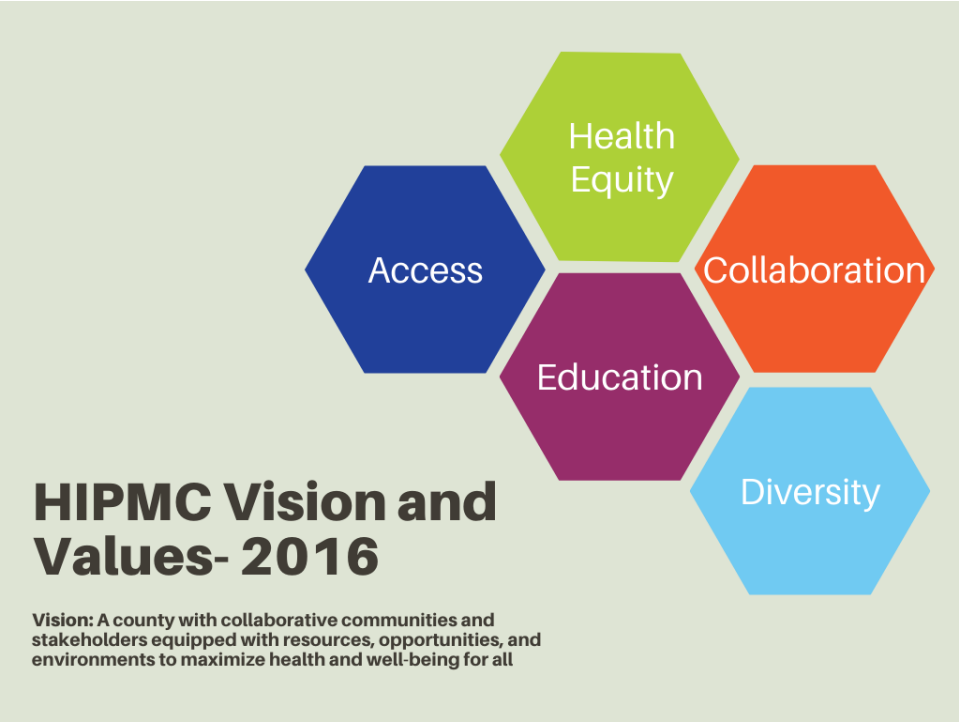
MCDPH staff supporting the HIPMC began initial preparations for the present MAPP cycle in the spring of 2015, including defining organizational tasks and setting a preliminary timeline. While the HIPMC and Synapse groups were already in place, partnership development and organization has been an ongoing process. Prior to fully engaging in the first phase of MAPP, the HIPMC Steering Committee was established in the fall of 2015 and its members were trained in the MAPP approach. Soon thereafter, the full HIPMC participated in a visioning session in October of 2015, and later received additional training in MAPP. Throughout the CCHNA process, the HIPMC and its Steering Committee have met on a quarterly basis and Synapse has met monthly. To plan these gatherings and support the CCHNA process overall, the MCDPH internal CHA/CHIP team has met monthly.



Phase 2 – Visioning

The second phase of MAPP, "visioning," inspires community stakeholders to think boldly in crafting a shared vision and common values.

HIPMC had previously established a vision statement when the group formed in 2012, but many new members had joined the group since then. The group also recognized the growth in their perspectives on their work. In particular, they felt the need to establish a clear set of values to ensure that their approaches would be equitable, transparent, accessible, and inclusive, that the community would drive and own the process, and that they could share power with those affected by the health inequities the group sought to address. While the MAPP process is to begin with visioning the HIPMC partnership, the group decided they wanted to continue with the current vision below.



HIPMC Vision – Revised

"A County with collaborative communities and stakeholders equipped with resources, opportunities, and environments to maximize health and well-being for all."

Phase 3 – The Four MAPP Assessments

Collecting and Analyzing Data

At the heart of the community health assessment stage are MAPP's four assessments. Together, they comprise the bulk of the information-gathering and analysis activities that produce the results needed to focus the subsequent community health improvement plan (CHIP). The assessments that make up Phase 3 of MAPP include:

3a. Community Health Status Assessment
3b. Local Public Health Systems Assessment
3c. Community Themes and Strengths Assessment
3d. Forces of Change Assessment

Each of the assessments are essential interlocking pieces in the jigsaw puzzle we must assemble to have an accurate portrait of our community and its health. Toward that end, each assessment seeks the answers to important questions that form and shape each piece of our community health puzzle.

What does the health status of the community look like? The Community Health Status Assessment (CHSA) may be what most people picture when talking about community health assessment. The CHSA's primary output is a community health profile that includes a collection of epidemiological statistics on a wide range of specific health conditions, leading causes of death, utilization of health care, etc. Because every possible health condition and consequence cannot be tracked, these statistics are a selected sub-set used as indicators for the overall health of the community.

How well are the 10 Essential Public Health Services being provided to the community? The Local Public Health System Assessment (LPHSA) examines the organized systems and resources that support public health and measures how well they function. The local health department is the primary focus of the assessment which is based on the National Public Health Performance Standards (NPHPS). NPHPS is a set of evaluation criteria created to assess the quality of public health programs and assistance in each of the ten essential public health service areas, identify areas in need of improvement, and strengthen the relationships existing between various agencies, organizations and governing bodies.

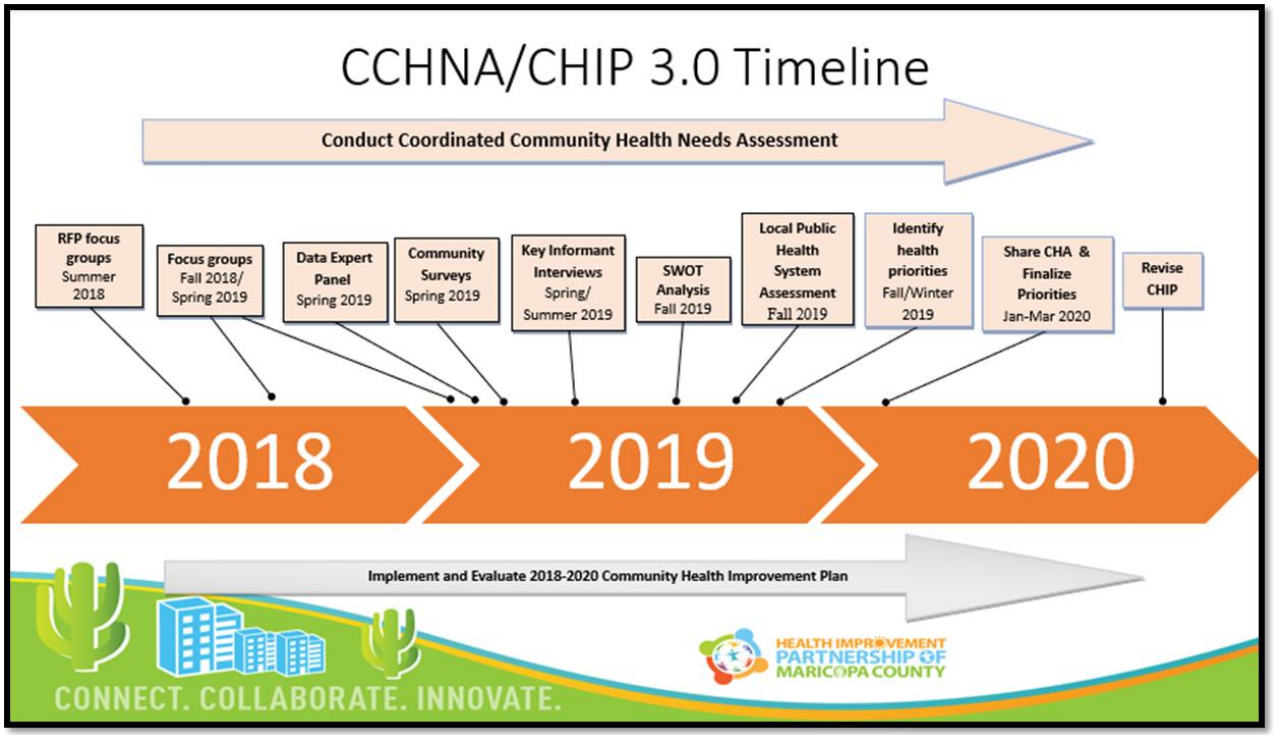
What is important to the community? And how can we build upon existing assets? The Community Themes and Strengths Assessment (CTSA) provides important community context to the assessment. The CTSA gathers input directly from community residents, with special attention to including traditionally underrepresented groups. While statistical data, like that from the CHSA, can give us facts and figures about health conditions in our community, the CTSA adds more meaning and significance to those facts by asking community members directly about what health issues are most important to them and what impact they see these having on their quality of life. The CTSA is an important source of "ground truth" based on input from community residents regarding their perceptions of the issues and their priorities for addressing them.

What internal and external forces are impacting the health of the community? The Forces of Change Assessment (FOCA) seeks to identify the events, trends, and other factors that influence the health of the community or the function of the local public health system. These events (like the loss of a major employer), trends (like an increasing population), or factors (like the urban or rural nature of a community) can produce specific challenges or threats that might negatively impact the community's health. They can also produce new opportunities that could be developed to generate positive impacts.

Gathering Information and Collecting Input

To provide a comprehensive and accurate perspective, the four assessments require large amounts of information. The process of gathering the information and input required for each of the assessments requires multiple activities and procedures that are complementary and overlapping. In the previous puzzle illustration, the four assessments formed interlocking pieces. Their interlocking nature not only reflects how the assessments support each other in forming a whole picture, but also how a data gathering activity intended to support one assessment may also reveal information applicable to another assessment. With this in mind, many of the data collection tools used were designed to gather information to feed more than one assessment.

The use of multiple information-gathering methods was also required to encompass the diverse sources needed for the broadest possible inclusion and engagement of community stakeholders with special attention given to ensure that traditionally underserved populations were appropriately represented. Toward those ends, the CCHNA relied on six major approaches to gather information and input for the four assessments. As shown in the next timeline below, data collection began in the fall of 2018 and continued through 2019 and was largely sequential, with some overlap that was made possible where the targeted audiences were substantially different.



Methods associated with each of the data collection tools are summarized briefly in the next sections that follow. Full details regarding the methods used and the results from each approach are presented in individual subsidiary reports that are *provided as separate Appendices to this CCHNA report, including:*

- *Maricopa County 2019 CCHNA Community Health Status Report*
- *Maricopa County 2019 CCHNA Community Health Surveys Report*
- *Maricopa County 2019 CCHNA Focus Groups Report*
- *Maricopa County 2019 CCHNA Key Informant Interviews Report*
- *Maricopa County 2019 CCHNA Local Public Health System Assessment Report*

Secondary Health Data

Maricopa County Department of Public Health (MCDPH) process for conducting Community Health Needs Assessment (CHNA) leveraged a multi-phased approach to understanding gaps in services provided to the community, as well as existing community resources. The CHNA utilized a mixed-methods approach that included the collection of secondary or quantitative data from existing data sources and community input or qualitative data from focus groups, and meetings with internal leadership. The advantage of using this approach is that it validates data by cross-verifying from a multitude of sources.

Many of the challenging health problems facing the United States in the 21st century require an understanding of the health not just of individuals but also of communities. The challenge of maintaining and improving community health has led to the development of a "population health" perspective. Population health can be defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group." A focus on population health implies a concern for the determinants of health for both individuals and communities. The health of a population grows directly out of the community's social and economic conditions as well as the quality of its medical care. As a result, the CHNA utilized a community health framework for this report to develop criteria for indicators used to measure health needs.

Partners selected approximately 100 data indicators to help examine the health needs of the community. These indicators were based on the Center for Disease Control and Prevention's (CDC) Community Health Assessment for Population Health Improvement: Most Frequently Recommended Health Metrics report[i]. While this report does not identify the specific indicators that should be utilized, it does specify the categories of information that should be considered.

The following five data categories describe the type of health factor and health outcome indicators utilized in the CHNA (See Table 1):

- ***Health Outcomes*** include morbidity, which refers to how healthy people are by measuring disease burden and quality of life (e.g. obesity rates, asthma incidence, and low birth weight babies, etc.); and mortality, which measures causes of death by density rates (e.g. cancer mortality, motor vehicle deaths, etc.);

- ***Health Care*** include access, which refers to factors that impact people's access to timely, affordable clinical care (e.g. primary care physicians, number of federally qualified health centers, etc.), and health insurance coverage.

- ***Health Behavior*** refers to the personal behaviors that influence an individual's health either positively or negatively (e.g. breastfeeding, physical activity, eating fruits and vegetables, etc.). This also includes delivery, which measures clinical care being delivered to the community (e.g. rate of preventive screenings, ambulatory care sensitive discharges, etc.).

- ***Demographics and Social Environment*** describe the population of interest by measuring its characteristics (e.g. total population, age breakdowns, limited English proficiency, etc.). Unlike other categories, demographic indicators are purely descriptive and not generally compared to benchmarks or viewed as positive or negative. This category also includes measures of social status, educational attainment, and income, all of which have a significant impact on an individual's health and.

- ***Physical and Built Environment*** measures characteristics of the built environment of a community that can impact the health of that community either positively or negatively (e.g. parks, grocery stores, walkability, etc.)

Table 1. Health Factor and Health Outcome Indicators

Health Outcome Metrics		Health Determinants and Correlated Metrics				
Mortality	**Morbidity**	**Access to Healthcare**	**Health Behaviors**	**Demographics**	**Social Environment**	**Physical & Built Environment**
Leading Causes of Death	Obesity	Health Insurance Coverage	Fruit & Vegetable Intake	Total Population	Domestic Violence and Child Abuse	Transportation
Infant Mortality	Cancer Rates	Quality of Care	Alcohol & Tobacco Use	Gender	Early Childhood Development	Parks and Recreation Access
Injury-related Mortality	Infectious Diseases	Prenatal Care	Physical Activity	Race/Ethnicity	Education System	Food Insecurity

Intentional Self-Harm	Chronic Diseases		Preventative Healthcare Utilization	Age Group		Lead Exposure
Homicide	Sexually Transmitted Diseases		Crime	Income		Housing Cost Burden
Chronic Disease Mortality	Mental Health					
Substance Use/Abuse Mortality						

Source: CDC's Community Health Assessment for Population Health Improvement: Most Frequently Recommended Health Metrics

Quantitative data was high quality, population-based data sources and were analyzed by MCDPH, Office of Epidemiology. Data came from local, state, and national sources such as the Maricopa County Department of Public Health, Arizona Department of Health Services, Arizona Criminal Justice Commission, U.S. Census Bureau, U.S. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System survey, and Youth Risk Behavior survey.

Epidemiology Expert Work Group

The Epidemiology Expert Workgroup (EEWG) was comprised of 5 community stakeholders holding various positions such as coordinators, supervisors, and epidemiologists from different organizations/agencies who met between February and June of 2019. The EEWG group met through a series of seven meetings for the epidemiology data review. Prior to beginning the project, each member of the workgroup was debriefed and received a general understanding of the Coordinated Community Health Needs Assessment (CCHNA) process and how their feedback will be used.

The EEWG reviewed over 212 indicators in 5 topic areas and scored each indicator on importance to public health, whether the issue/problem was actionable at the community level, if the indicator is linked to a prevention or intervention, and if there are barriers affecting change. All indicators that received an average score of 90% or higher during that review received a "Yes" on the Indicator Matrix for Data Support from the EEWG. This was necessary because much of the data reviewed by EEWG was extensive and granular, much more so than could be collected from any of the other data sources. Although new priorities were not identified, the prioritization matrix method was utilized to derive our current three priorities of access to care, access to healthy food, and early childhood development.

LPHSA Instrument

The Local Public Health Systems Assessment (LPHSA) examines the organized systems and resources that support public health and measures how well they function. The local health system is the primary focus of the assessment which is based on the National Public Health Performance Standards (NPHPS). NPHPS is organized around ten essential public health services that should be found in every public health system. NPHPS provides two to four model standards for key functions required to perform each of the essential services. In turn, there are two to five performance measures to assess each of the model standards. In total, this makes for ten essentials services, 30 model standards, and 98 performance measures.

The LPHSA Instrument is a survey-like tool used to rate the local public health system's performance according to each of the NPHPS criteria. The instrument was created by a cooperative effort supported by the CDC and involving six national public health organizations. The instrument is regularly updated and published by the National Association of County & City Health Officials (NACCHO). The instrument consists of a series of 98 questions, one for each of the performance measures. Each question asks the respondent to rank the level at which the local public health system performs activities related to the performance measure, with responses on a 5-point scale including no, minimal, moderate, significant, or optimal activity. Ideally, the instrument is used in a group setting where a collection of local public health system representatives and partners can be led through a facilitated discussion of each model standard and the performance of the local system can be debated and a final ranking determined through a voting process. Often, several small group meetings are held to address only a few of the essential services at a time, with the participants selected for their expertise specific to those services, and this was the primary approach used for Maricopa County's LPHSA.

Representatives from community partner organizations were invited to participate in the 2020 LPHSA and asked to complete a Qualtrics questionnaire about their daily work based on the sector and specific Essential Public Health Service they work with. A total of 48 assessments were completed by professionals in various public-health related organizations and agencies within Maricopa County, Arizona area. Participants were asked to complete the assessment section for which they were most familiar and had the most experience working in, pertaining specifically to Maricopa County. Quantitative data were processed with an online tool provided by the Public Health Foundation to calculate performance scores in each area. Qualitative analysis was performed to identify key themes from comments made during the group meetings. Selected highlights from these results are presented in the LPHSA Chapter found later in this report. Full results are included in the separate *Maricopa County 2019 CCHNA Local Public Health System Assessment Report* (Appendix C).

Community Surveys

Broad-based community input is essential to any community health assessment. Toward that end, MCDPH partnered with a wide variety of community-based agencies and healthcare partners to distribute and collect community surveys from residents and professionals within Maricopa County.

The surveys were based on an example developed by the National Association of County & City Health Officials (NACCHO). This was modified by members of HIPMC, Synapse, and MCDPH staff to expand its response options to include additional health issues and determinants. The survey was designed in two versions, one to be applicable to community and another for professional audiences. The community version had a total of 22 questions and asked respondents to identify factors which contribute to overall quality of life, note the most important health issues and behaviors observed in the community, rate the health of themselves and/or the community, and to provide personal demographic information.

The survey was widely publicized on MCDPH websites and social media platforms, and members of the HIPMC and Synapse distributed marketing materials for the survey throughout their networks. The questionnaire was provided on a digital platform using Qualtrics and hosted on the Maricopa Health Matters website (maricopahealthmatters.org) in addition to a paper format. Paper copies were located at several WIC locations throughout Maricopa County and at the Maricopa County Office of Vital Registration in Central Phoenix. Additionally, several non-profit community agencies were contracted to aid with the collection of surveys from traditionally under-represented groups and minorities.

A total of 11,893 surveys were collected from community residents age 14 and above within Maricopa County. Participants were allowed to take both surveys if they chose to. A complete description of the respondents' demographics, along with the full results of the surveys, are provided in the *Maricopa County 2019 CCHNA Community Health Surveys Report* (Appendix D). Primarily, the surveys were meant to support the Community Themes and Strengths Assessment (CTSA), but also informed the Community Health Status Assessment (CHSA) and the Forces of Change Assessment (FOCA). Relevant results from the surveys are featured in each of the chapters for these assessments found later in this report.

Focus Groups

Many minority and other groups are commonly underserved by public health and health care systems and other support services. Often, these groups are also under-represented in public surveys and other forms of data collection. To ensure that the unique concerns of these groups were not overlooked in the CCHNA, MCDPH and its partners contracted with the Southwest Interdisciplinary Research Center (SIRC) at Arizona State University to conduct a series of focus groups with medically underserved populations across Maricopa County, including:

- African American community
- Native American community
- Congolese community
- Hispanic/Latino community
- Filipino community
- Lesbian, Gay, Bisexual, Transgender and Questioning community
- Homeless populations

- Older adults
- Young adults
- Veterans
- Migrant seasonal farmworkers
- Incarcerated community
- People in rural communities
- New parents and parents of children with special health care needs

To reach these populations, SIRC recruited 485 residents from the target groups who participated in focus groups conducted at locations throughout the county. A total of 52 focus groups were conducted between August 2018 and December 2019. All participants provided informed consent, and each was offered a modest stipend in the form of a gift card and refreshments which included a light meal and healthy beverages.

Each focus group session was led by a trained facilitator who guided the participants through a set of discussion questions intended to uncover barriers and pathways to community health, cultural components of health and health-seeking behaviors, quality of life indicators, and the most salient conditions currently impacting health in Maricopa County. Sessions were recorded and transcribed for later analysis to identify key themes. Note-takers also took notes during the session in case of audio device failure and to note interruptions in recordings.

Primarily, the focus groups were meant to support the Community Themes and Strengths Assessment (CTSA), but also informed the Community Health Status Assessment (CHSA) and the Forces of Change Assessment (FOCA). Relevant results from the focus groups are featured in each of the chapters for these assessments found later in this report.

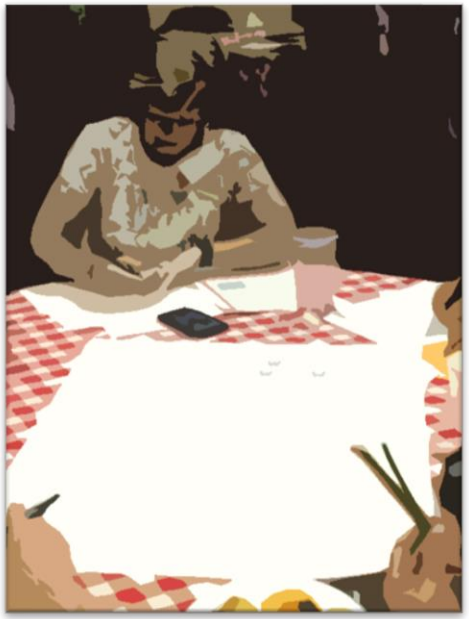
Complete details of focus groups, including methods used, participant demographics, and full results, are provided in the *Maricopa County 2019 CCHNA Focus Groups Report* (Appendix E).

Key Informant Interviews

Key Informant Interviews (KIIs) are a common qualitative research tool to gather input from individuals who hold strategic positions in an organization or community. Through their exclusive positions, these individuals may have unique perspectives on policies and systems and may offer authoritative information not generally available.

Although professionals were a target for one of the community surveys, KIIs were employed to reach key community leaders with the goal of gaining deeper insight into the essential needs of the community and how vital issues might be addressed.

Recruitment targeted leaders from 11 different community sectors, including: built environment, business, education, grassroot community leaders, elected officials, healthcare, justice/law enforcement, philanthropy, public health, state/local government/military, and volunteer/civic. Members from three local coalitions, HIPMC, Synapse, and Collective STEP for Youth nominated individuals for the KIIs, and selections were made by MDCPH staff based on the number of nominations and the distribution among sectors.



A total of 24 individuals were invited to participate, and 21 interviews were ultimately conducted during October and November of 2019. Interviews were performed by MCDPH staff members specially trained in the interview protocol. All informants provided informed consent, and no incentives were offered for their participation. Interviews were semi-structured around 12 discussion and 3 supplemental questions designed to elicit opinions on the nature of community health and its current status in Maricopa County. Questions also asked interviewees to identify any trends and people or organizations that may be influencing the community, and to describe their perceptions of the leading community health concerns and any barriers that stand in the way of addressing those concerns. Known community strengths and resources were also queried.

Interviews were recorded and transcribed for later analysis. The analysis involved reviewing transcripts using computer software to code responses and identify recurrent themes both across the entire interview and specifically within the responses to each question.

While primarily intended to support the Forces of Change Assessment, the KIIs also informed the Community Themes and Strengths Assessment. Relevant results from the KIIs are featured in the chapters for these assessments found later in this report. A more thorough description of the KII methodology, participant demographics, and complete results can be found in the *Maricopa County 2019 CCHNA Key Informant Interviews Report* (Appendix F).

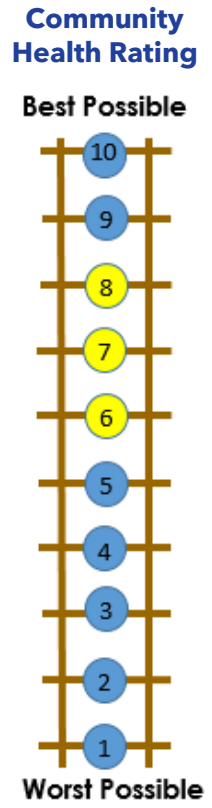
Phase 3a – Community Health Status Assessment

What does the health status of the community look like? The Community Health Status Assessment (CHSA) may be what most people picture when talking about community health assessment. The CHSA's primary output is a community health profile that includes a collection of epidemiological statistics on a wide range of specific health conditions, leading causes of death, utilization of health care, etc. The CHSA relies on a combination of existing statistical health information and new qualitative information collected as part of the other assessments in MAPP that reflect the community's perceptions and priorities.

Community Health Profile

When the 2019 CCHNA community survey asked local residents – "Imagine a ladder with steps numbered from one at the bottom to ten at the top. The top of the ladder represents the best possible life and the bottom of the ladder represents the worse possible life. Which step represents the health of your community?" – the majority (58.4%) of community members reported that step 6, 7, or 8 represent the health of their community. This sentiment was shared with key informants who rated the health and quality of life for Maricopa County residents near the middle of the scale at 5.8 which was determined by averaging all ratings provided. Respondents reported there is still a lot more to be done around the lack of access to resources, disease prevention, and provision of holistic healthcare, all of which disproportionately affect disadvantaged populations.

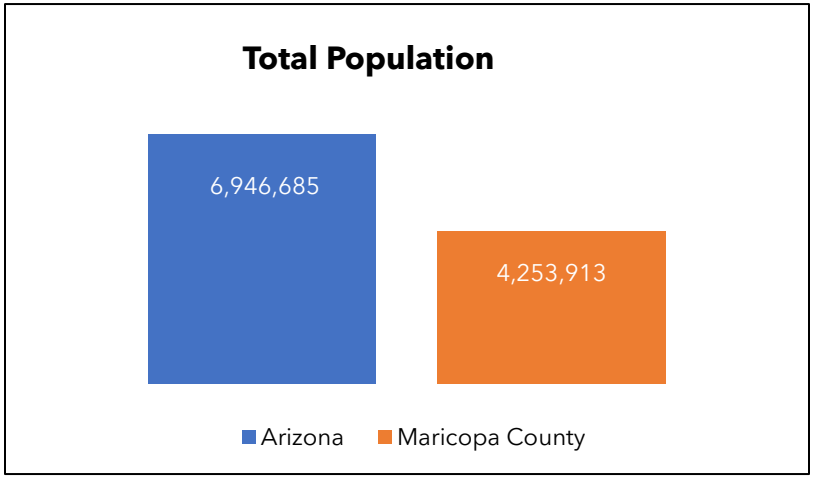
The abbreviated profile that follows includes a selection of indicators that highlights key facts, trends, and notable disparities in the health of our community's residents. For a full accounting of all the community health indicators selected by the Epidemiology Expert Work Group, please see the separate Maricopa County 2019 CCHNA Community Health Status Report *(*Appendix B). That report also contains citations for sources of all the secondary data described in the figures and tables found in this chapter.

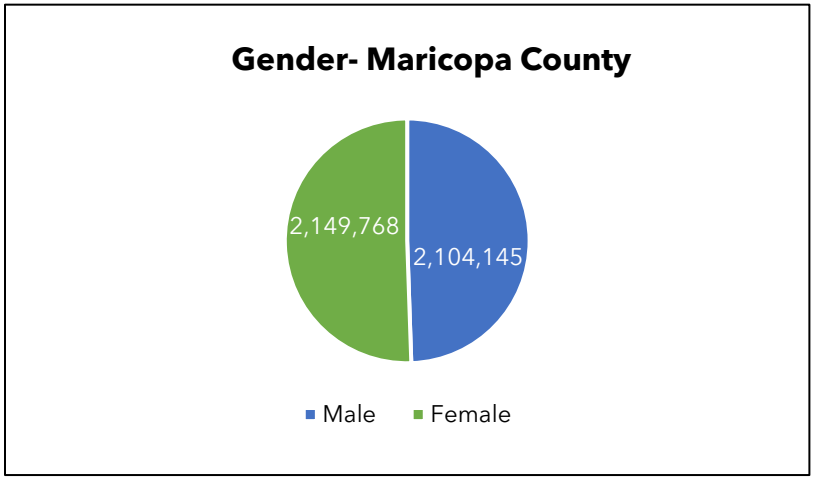


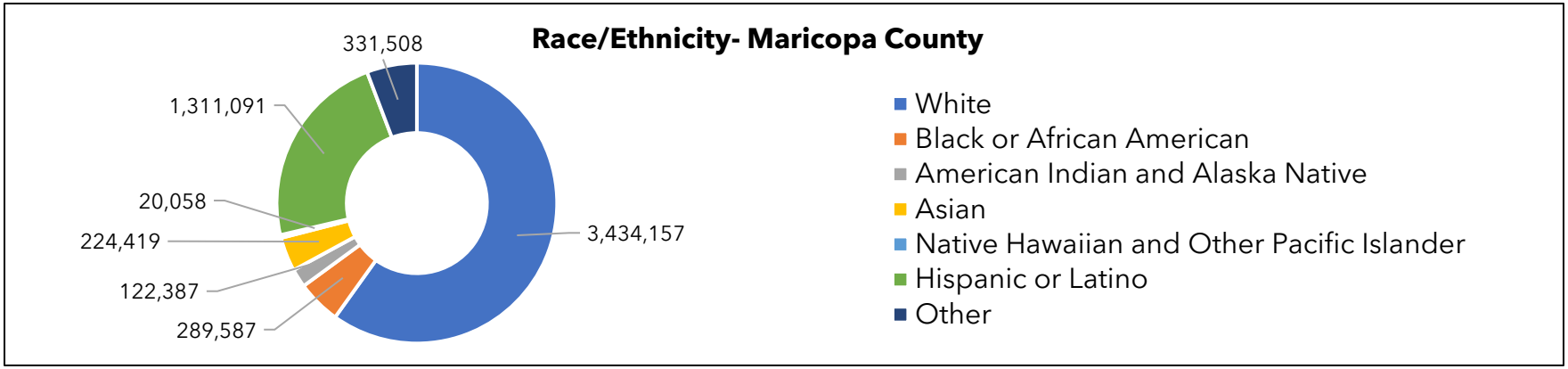
Demographics

Population

Maricopa County's population of more than 4.4 million people makes it the fourth most populous county in the country and the nation's third largest public health jurisdiction. Gender distribution is approximately equal across Maricopa County, the state, and the nation. The age distribution for Maricopa County (and Arizona) is slightly younger than that of the U.S. as a whole. Maricopa County (and Arizona) has a notably larger proportion of Hispanics than the nation, at almost double the percentage. Maricopa County (and Arizona) also has a greater percentage of American Indians. In contrast, Maricopa County's proportion of African Americans is substantially lower.



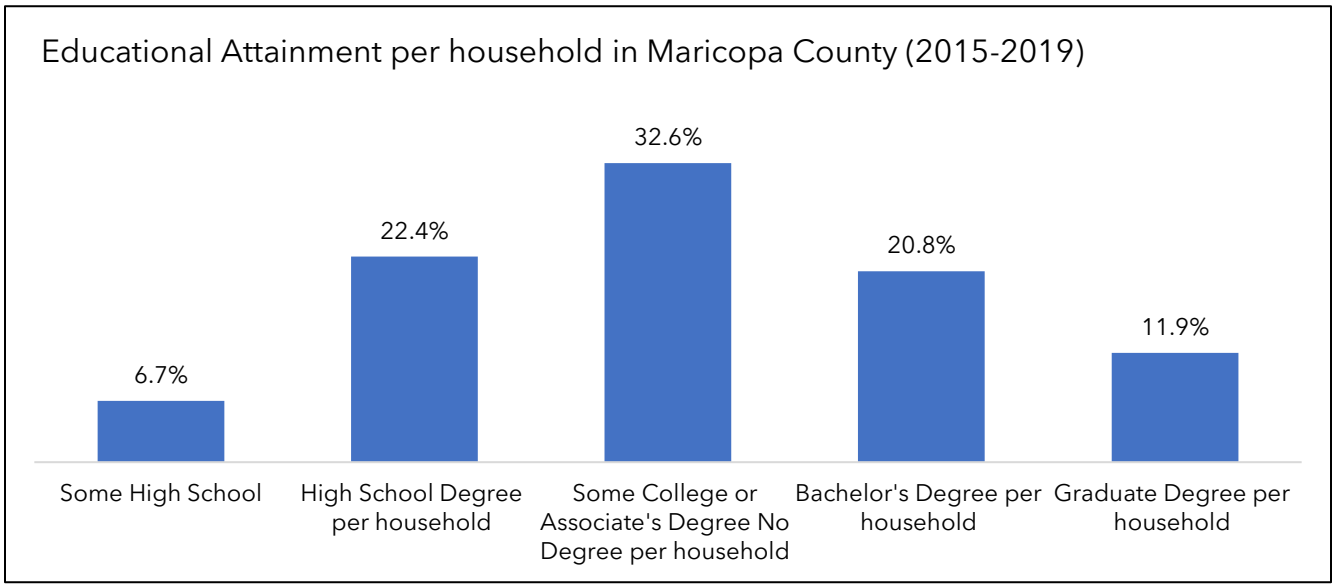




Source: Census

Educational Attainment

Educational Attainment refers to the highest level of education that an individual has completed. The data below represents 5-year estimates In Maricopa County per household.



Source: U.S. Census Bureau. 2015-2019 American Community Survey (ACS) 5-Year Estimates

Income/Poverty

The 2019 U.S. median household income was $65,712. Real median household income in the United States increased 4.5% between the 2018 and 2019 American Community Survey (ACS). The national poverty rate was 13.4% in 2019, a decline from 13.1% in 2018. The 0.8 percentage-point decrease in the percent of the U.S. population with income below the poverty level was among the largest declines in year-to-year poverty rates since the inception of the ACS in 2005.[4] In Maricopa County, the median household income was $64,468, while the poverty rate was 13.7%, exceeding the national rate.[1]

Mortality

Mortality rate is the rate of deaths or number of people who died within a population. Mortality data looks at the prevalence of diseases, how likely a particular disease is to be deadly, and if it impacts specific demographics. Mortality rates are represented by the number of deaths per 100,000 individuals per year unless otherwise noted.

Rank	Maricopa County Leading Causes of Death (2019) – All Race/Ethnicities
1	Cardiovascular Disease
2	Cancer
3	Chronic Lower Respiratory
4	Alzheimer's
5	Unintentional Injury
6	Stroke
7	Diabetes
8	Suicide
9	Fall
10	Influenza / Pneumonia

Rank	White	Hispanic	African American	American Indian	Asian
1	Cardiovascular Disease	Cancer	Cardiovascular Disease	Cancer	Cancer
2	Cancer	Cardiovascular Disease	Cancer	Unintentional Injury	Cardiovascular Disease
3	Chronic Lower Respiratory	Unintentional Injury	Unintentional Injury	Cardiovascular Disease	Stroke
4	Alzheimer's	Diabetes	Diabetes	Diabetes	Unintentional Injury
5	Stroke	Stroke	Stroke	Liver Disease	Diabetes
6	Unintentional Injury	Alzheimer's	Chronic Lower Respiratory	*	Alzheimer's
7	Diabetes	Liver Disease	Alzheimer's	*Less than 20 per category	

8	Fall	Chronic Lower Respiratory	Homicide	
9	Suicide	Suicide	Suicide	
10	Influenza / Pneumonia	Pregnancy and Early Life	Pregnancy and Early Life	

Source: Office of Vital Records, death certificate

Morbidity

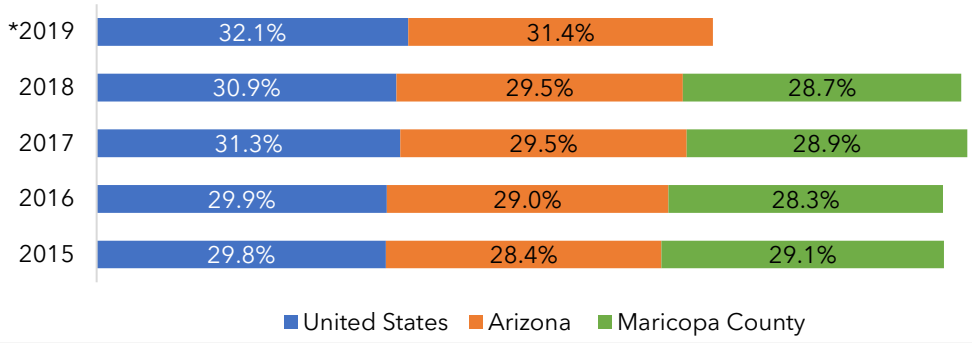
Morbidity refers to the state of being symptomatic or unhealthy for a disease or condition. It is usually represented or estimated using prevalence or incidence. Prevalence describes the proportion of the population with a given symptom or quality. It is calculated by dividing the number of affected individuals by the total number of individuals within a specific population. Incidence demonstrates the frequency at which individuals within a specific population develop a given symptom or quality. It is calculated by dividing the number of new cases within a designated, particular period by the number of individuals within the population.[5]

Chronic Diseases

Obesity

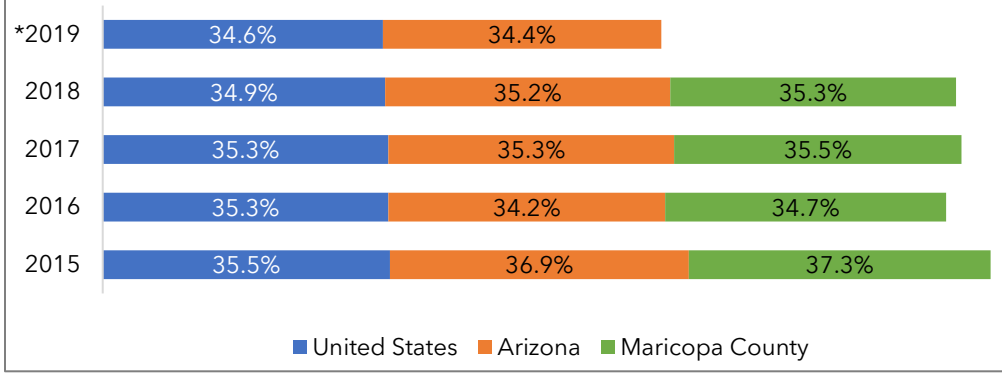
According to the World Health Organization, overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health. The fundamental cause of overweight and obesity is an energy imbalance between calories consumed and calories expended. Some common health consequences of overweight and obesity are cardiovascular disease (mainly heart disease and stroke), diabetes, musculoskeletal disorders, and some cancers (endometrial, breast, ovarian, prostate, liver, gallbladder, kidney, and colon. Overweight and obesity as well as their related noncommunicable diseases are largely preventable.

The **United States** had a higher percentage of adults considered obese compared to **Arizona** and **Maricopa County**.



*County level data for 2019 was unavailable to report out, Source: https://www.cdc.gov/brfss/brfssprevalence/, https://www.maricopa.gov/Archive.aspx?AMID=101

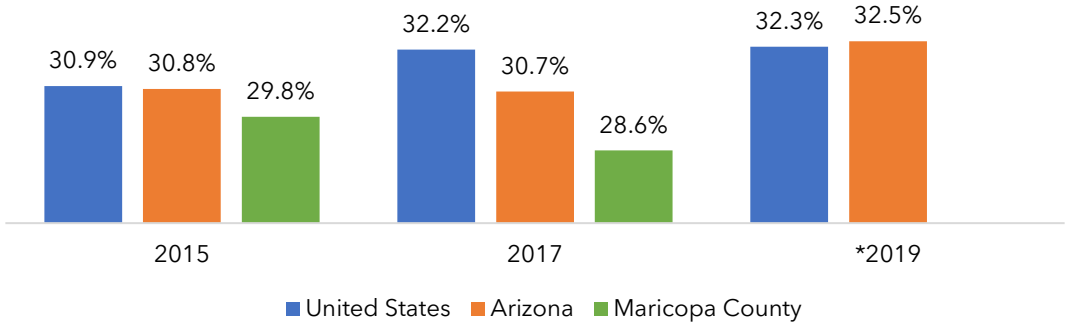
Maricopa County had a higher percentage of adults considered overweight compared to **Arizona** and the **United States**.



Supportive environments and communities are fundamental in shaping people's choices, by making the choice of healthier foods and regular physical activity the easiest choice (the choice that is most accessible, available, and affordable and therefore preventing overweight and obesity.[6]

High Blood Pressure & Cholesterol

Maricopa County had a lower percentage of adults who had been told they have high blood pressure compared to **Arizona** and the **United States**.



High blood pressure increases the risk for heart disease and stroke, two leading causes of death for Americans. Tens of millions of adults in the United States have high blood pressure, and many do not have it under control.[7] About 38% of American adults have high cholesterol (total blood cholesterol >200 mg/dL). Too much cholesterol also puts you at risk for heart disease and stroke.[8] Both high blood pressure and high cholesterol do not have signs and symptoms, so the only way to know if you have it is to get your blood pressure measured and cholesterol checked.[7,8]

*County level data for 2019 was unavailable to report

Source: https://www.cdc.gov/brfss/brfssprevalence/, https://www.maricopa.gov/Archive.aspx?AMID=101

Asthma

According to the Centers for Disease Control and Prevention, asthma is a chronic disease that affects adults and children of all ages. Asthma is characterized by repeated episodes of wheezing, breathlessness, chest tightness, and nighttime or early morning coughing. We don't know all the things that can cause asthma, but we do know that genetic, environmental, and occupational factors have been linked to developing asthma. Asthma can be controlled by taking medicine and avoiding the triggers that can cause an attack.[9]

	Arizona (per 1,000)	Maricopa County (per 1,000)
2015	3.4	3.1
2016	1.3	1.3
2017	1.2	1.3
2018	1.0	1.0

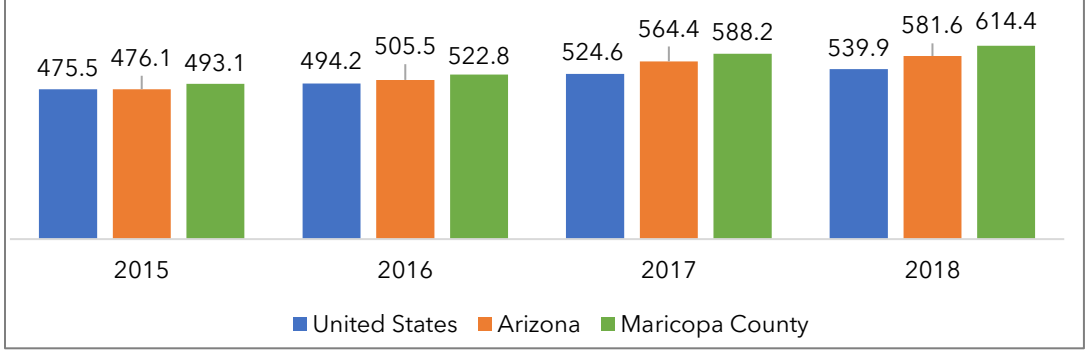
Source: https://pub.azdhs.gov/health-stats/hip/index.php?pg=asthma

Sexually Transmitted Diseases

Chlamydia

Chlamydia is the most frequently reported bacterial sexually transmitted infection in the United States. In 2018, 1,758,668 cases of chlamydia were reported to CDC from 50 states and the District of Columbia, but an estimated 2.86 million infections occur annually. Almost two-thirds of new chlamydia infections occur among youth aged 15-24.[10] The graph below shows the prevalence rate of chlamydia cases between 2015 and 2018. In Maricopa County, the number of chlamydia cases exceed the national rate followed by the state of Arizona.

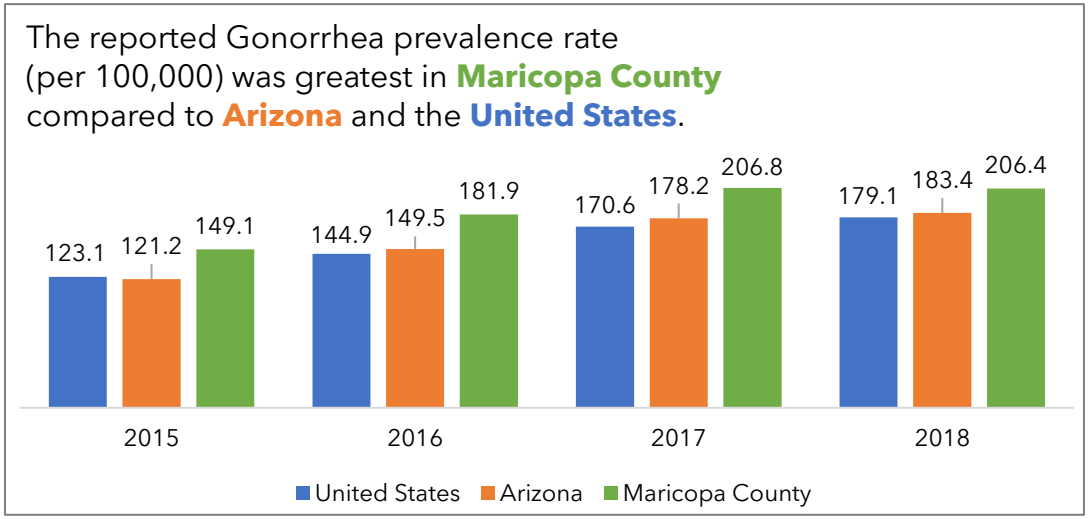
Maricopa County had the highest reported Chlamydia prevalence rate (per 100,000) compared to **Arizona** and the **United States**.



Source: https://gis.cdc.gov/grasp/nchhstpatlas/tables.html

Gonorrhea

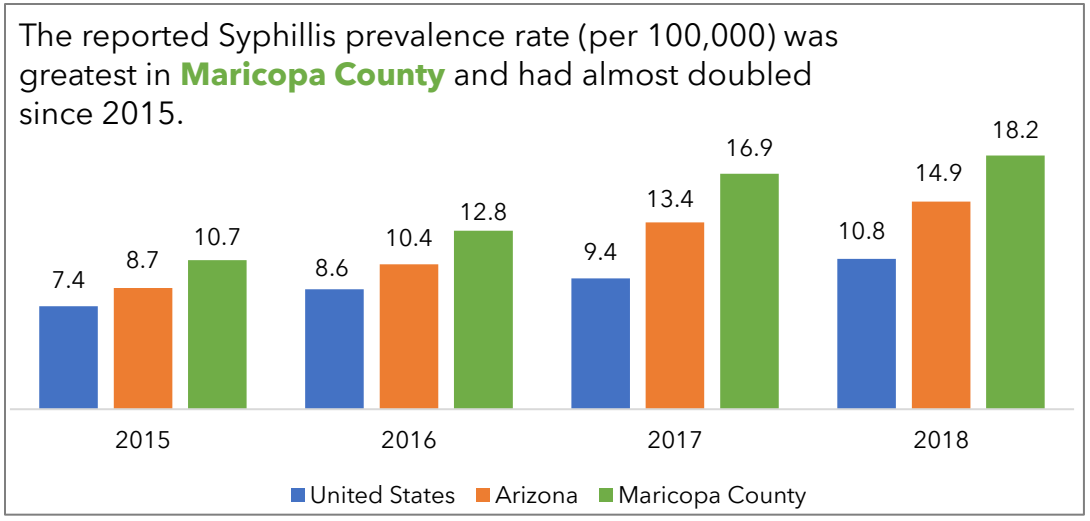
Gonorrhea is the second most reported notifiable disease in the United States. In 2018, a total of 583,405 cases of gonorrhea were reported in the United States, yielding a rate of 179.1 cases per 100,000 population. During 2017-2018, the rate of reported gonorrhea cases increased 5.0% and increased 82.6% since the historic low in 2009.[11] The graph below shows prevalence rates of gonorrhea cases between 2015 and 2018. In Maricopa County, the prevalence of chlamydia cases reached the highest in 2017 and 2018.



Source: https://gis.cdc.gov/grasp/nchhstpatlas/tables.html

Syphilis

Syphilis is a sexually transmitted disease caused by the bacterium *Treponema pallidum*. Syphilis can cause serious health conditions if not adequately treated. During 2018, there were 115,045 reported new diagnoses of syphilis (all stages), compared to 38,739 estimated new diagnoses of HIV infection in 2017 and 583,405 cases of gonorrhea in 2018. Of syphilis cases, 35,063 were primary and secondary (P&S) syphilis, the earliest and most transmissible stages of syphilis.[12] The graph shows the prevalence rates of syphilis cases between 2015 and 2018.

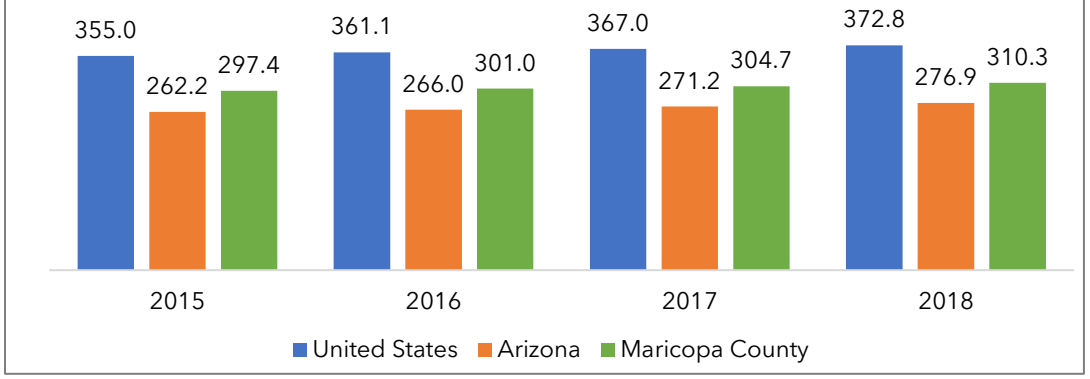


Source: https://gis.cdc.gov/grasp/nchhstpatlas/tables.html

HIV/AIDS

The human immunodeficiency virus (HIV) targets the immune system and weakens people's defense against many infections and some types of cancer. HIV continues to be a major public health issues, having claimed almost 33 million lives so far. At the end of 2019, there were an estimated 38.0 million people living with HIV.

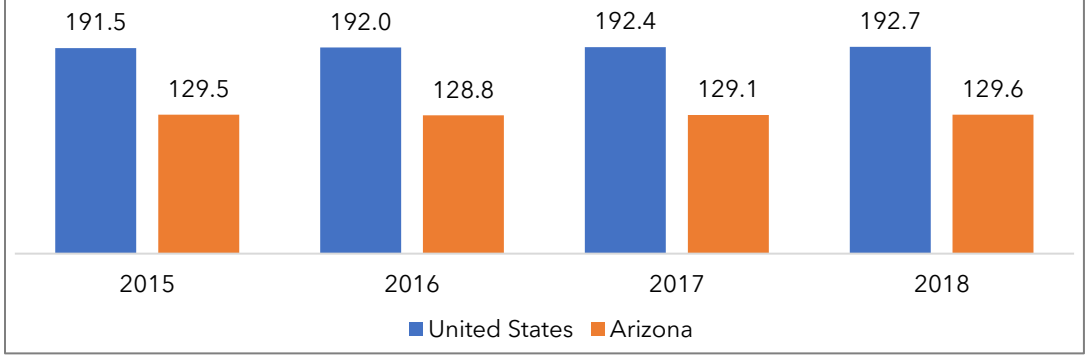
The reported HIV prevalence rate (per 100,000) was greatest in the **United States** followed by **Maricopa County**.



Source: https://gis.cdc.gov/grasp/nchhstpatlas/tables.html

Due to the gaps in HIV services, 690,000 people died from HIV-related causes in 2019 and 1.7 million people were newly infected. There is no cure for HIV infection, however effective prevention interventions are available: preventing mother-to-child transmission, male and female condom use, harm reduction interventions, pre-exposure prophylaxis, etc. The most advanced stage of HIV infection is acquired immunodeficiency syndrome (AIDS). AIDS is defined by the development of certain cancers, infections, or other severe long-term clinical manifestations.[13]

The reported AIDS prevalence rate (per 100,000) continued to gradually increase in the **United States** and **Arizona**.

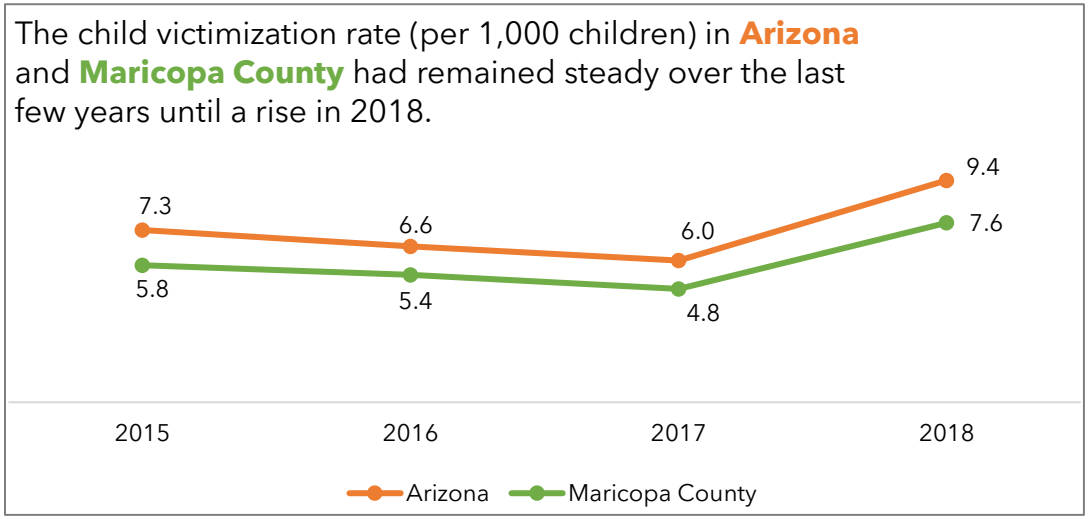


Source: https://gis.cdc.gov/grasp/nchhstpatlas/tables.html

Social Environment

Child Abuse

The Federal Child Abuse Prevention and Treatment Act (CAPTA) defines child abuse and neglect as, at a minimum, "any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation. Most states recognize four major types of maltreatment: physical abuse, neglect, sexual abuse, and emotional abuse. Child abuse and neglect can have lifelong implications for victims, including on their well-being. While the physical wounds may heal, there are many long-term consequences of experiencing the trauma of abuse or neglect. Children who are maltreated may be at risk of experiencing cognitive delays and emotional difficulties, among other issues, which can affect many aspects of their lives, including their academic outcomes and social skills development.[14]

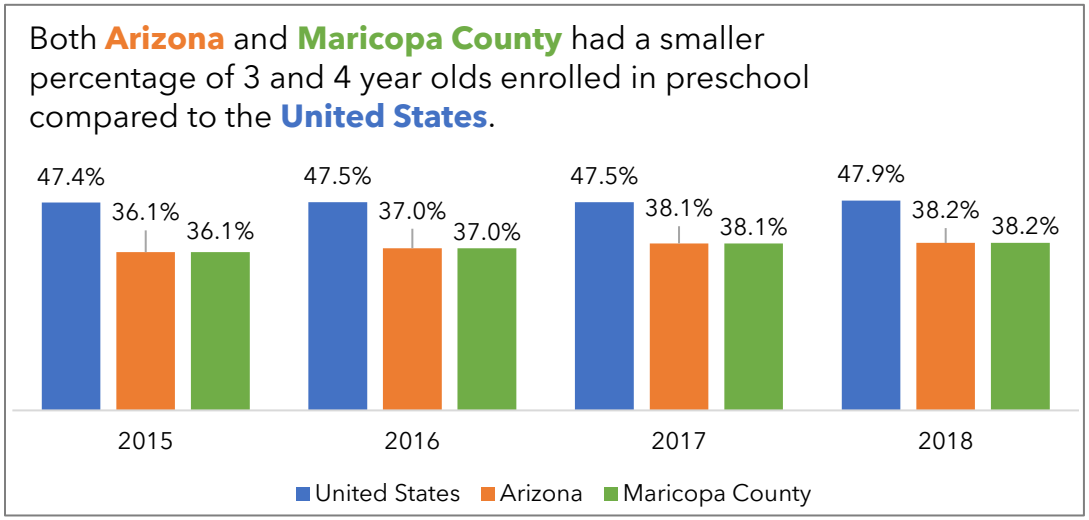


Source: https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/child-maltreatment
NCANDS Data- Analysis by MCDPH Office of Epidemiology

Early Childhood Development

The American Academy of Pediatrics (AAP) reported that children born into poverty have greater odds of not being ready for school than children not born into poverty. Children growing up in household poverty often have a home environment that is less supportive of school readiness. The reasons for less support in the environment could be that mothers living in household poverty are more likely to experience increased drug/alcohol use, low maternal education, and social isolation.[15]

Most children in the United States attend early care and education (ECE) such as public or private preschool, childcare centers, or Head Start before entering kindergarten. In preschool, children can learn to strengthen their social and emotional development. Preschool provides an environment for children to explore, gain a sense of self, play with pers, and build self-confidence. A quality early childhood education provides children with cognitive, behavioral, and social skills that they don't learn at home.[16]



Source: https://data.census.gov/cedsci/table?q=S1401&tid=ACSST5Y2013.S1401

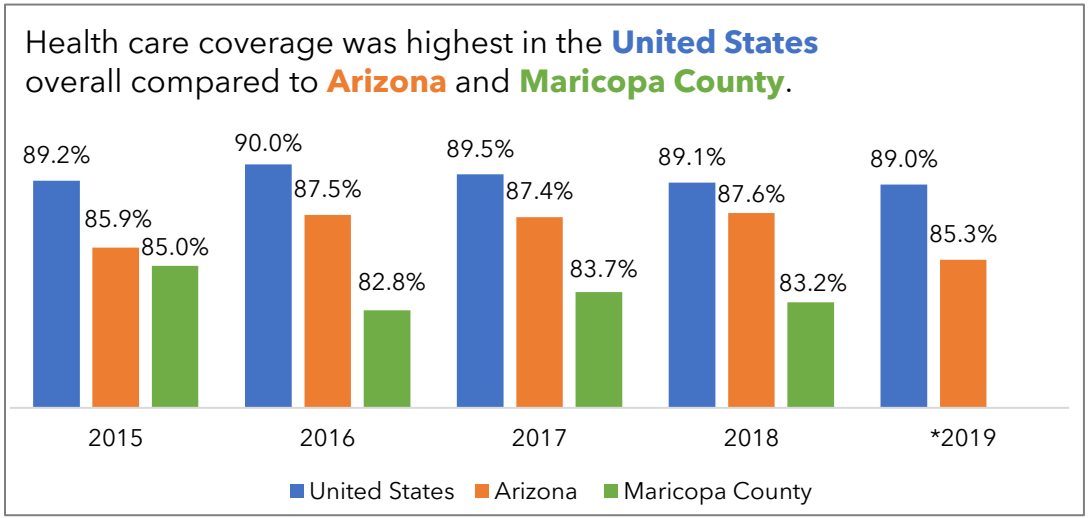
Access to Health Care

Access to health care was ranked first among the "most important health problems that impact your community" in the community survey. Access to health care was number one for all special populations except veterans. Access to health care ranked highest for all age groups except 75+. Access to comprehensive, quality health care services is important for promoting and maintaining health, preventing, and managing disease, reducing unnecessary disability and premature death, and achieving health equity for all Americans. Access to health care impacts one's overall physical, social, and mental health status and quality of life. Barriers to health services include high cost of care, inadequate or no insurance coverage, lack of availability of services and lack of culturally competent care. These barriers to accessing health services lead to unmet health needs, delays in receiving appropriate care, inability to get preventive services, financial burdens, and preventable hospitalizations.[17]

Health insurance coverage helps individuals enter the health care system. Lack of adequate coverage makes it difficult for people to get the health care they need and, when they do get care, burdens them with large medical bills. Uninsured people are:

- More likely to have poor health status
- Less likely to receive medical care
- More likely to be diagnosed later
- More likely to die prematurely

Improving access to health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes, fewer disparities, and lower costs. Having a primary care provider (PCP) who serves as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Improving health care services include increasing access to and use of evidence-based preventive services that prevent illness by promoting healthy behaviors, providing protection to those at risk, and identifying and treating people with no symptoms, but who have risk factors before the clinical illness develops.[17] The cost of health care is a major determinant of its use. Healthcare insurance coverage is one buffer that can improve access to health care.



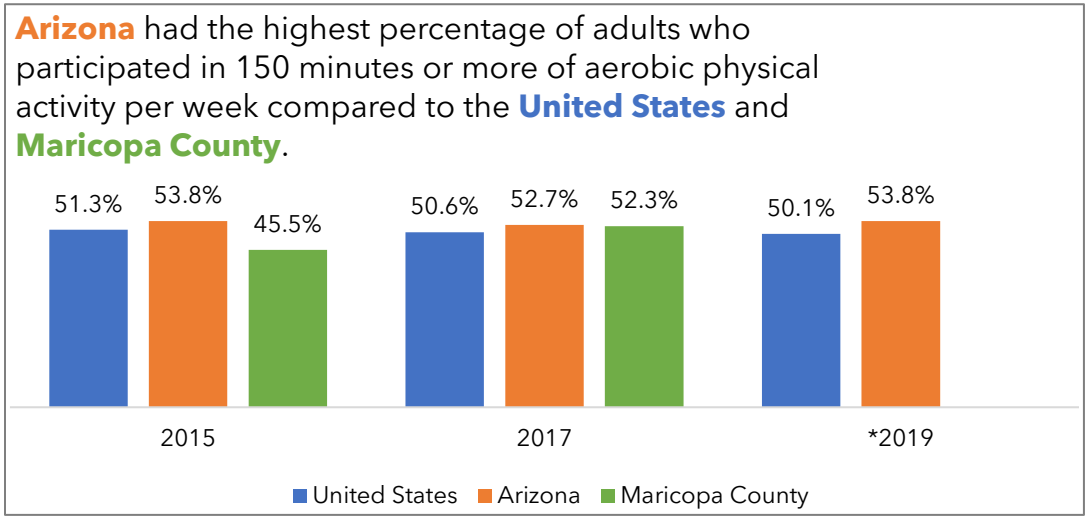
**County level data for 2019 was unavailable to report out*
Source: https://www.cdc.gov/brfss/brfssprevalence/, https://www.maricopa.gov/Archive.aspx?AMID=101

Health Behaviors

Health behaviors shape health and well-being in individuals and populations. These behaviors are actions taken by individuals that affect health or mortality. Actions that can be classified as health behaviors are many; examples include smoking, substance abuse, diet, physical activity, sleep, risky sexual activities, and health care seeking behaviors. Addressing the social determinants of health helps us recognize that overall health and health disparities are shaped significantly by nonmedical factors. While these nonmedical factors include individual characteristics such as education, income, and health beliefs many others derive from an individual's social and physical contexts – families, schools, workplaces, and neighborhoods – "upstream" factors that further enable or constrain health.[18]

Physical Activity

Physical activity is an important factor in health and can reduce risk of many lifestyle-associated diseases like diabetes, heart disease, and stroke. In our community surveys, lack of exercise rated fifth among the most important unhealthy behaviors seen in the community. The percentage of adults in Maricopa County who meet recommended exercise guidelines has fallen below the national level and is well below targets set by Healthy People 2020.



**County level data for 2019 was unavailable to report out*
Source: https://www.cdc.gov/brfss/brfssprevalence/, https://www.maricopa.gov/Archive.aspx?AMID=101

Diet and Nutrition

Diet and nutrition make significant contributions to our health. Poor eating habits can lead to becoming overweight or obese, and increases our risk of diabetes, heart disease, stroke, and other serious health problems. In our community surveys, poor eating habits rated fourth among the most important unhealthy health behaviors seen in the community.

Fruit Consumption- Less than 1 time per day

	United States	Arizona

2015	39.7%	39.7%
2017	36.6%	37.0%
2019	39.3%	38.3%

Source: https://www.cdc.gov/brfss/brfssprevalence/

Vegetable Consumption- Less than 1 time per day

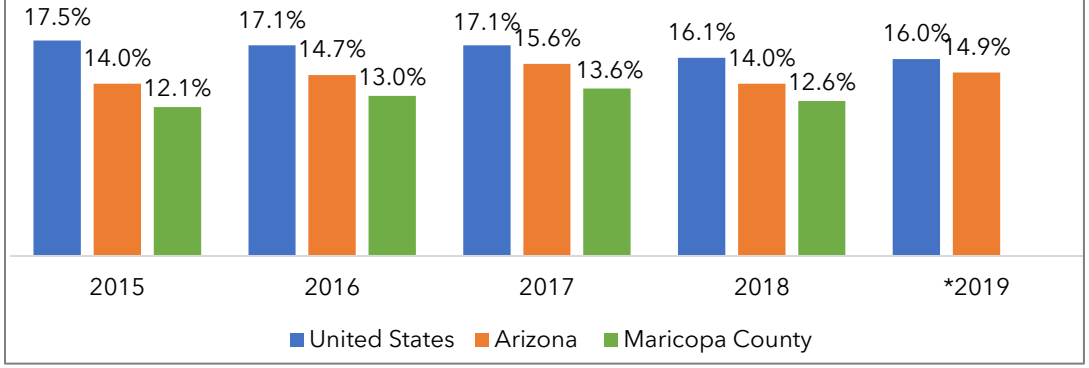
	United States	Arizona
2015	22.1%	20.5%
2017	18.1%	20.6%
2019	20.3%	21.6%

Source: https://www.cdc.gov/brfss/brfssprevalence/

Alcohol, Tobacco, and Other Drug Use/Abuse

Substance use and abuse contributes to many health problems. Tobacco use is associated with cancers of the lung and upper respiratory track, including the throat and mouth. Excessive drinking can lead to liver problems, and drug abuse can lead to overdose and death. In our community surveys, alcohol and drug abuse were rated as the first and second most important unhealthy behaviors seen in the community. Tobacco use was ranked seventh in importance.

Maricopa County had the lowest percentage of adults who were current smokers compared to **Arizona** and the **United States**.



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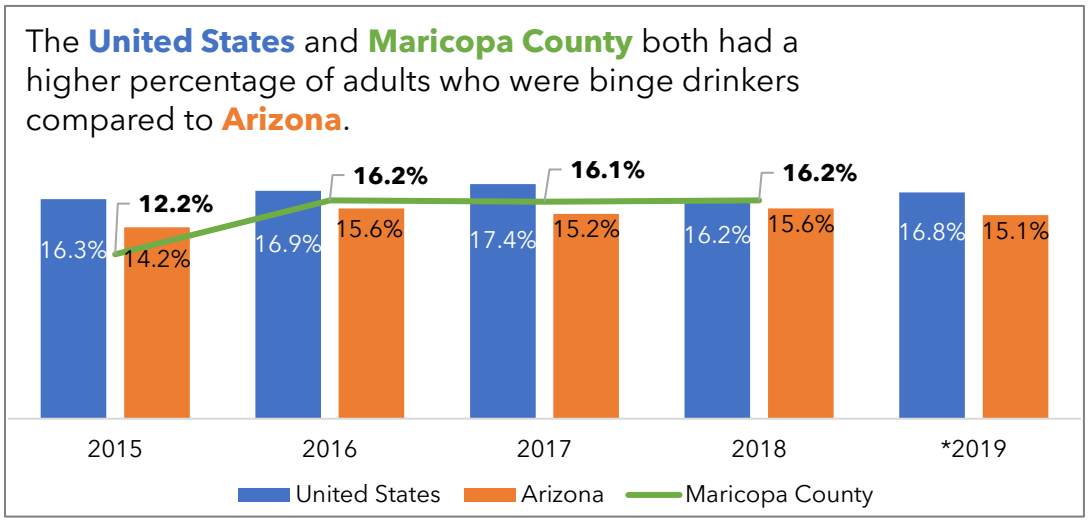


**County level data for 2019 was unavailable to report*
Source: https://www.cdc.gov/brfss/brfssprevalence/, https://www.maricopa.gov/Archive.aspx?AMID=101

Preventive Health Care Utilization

Many preventive services can reduce the risk of serious health problems. Screenings can detect risk factors or signs of disease early enough to reduce the severity of later consequences. Vaccinations may be one of the greatest public health triumphs in history and has contributed to the eradication of some formerly common and potentially deadly infectious diseases, and the tight control of many others. The use of preventive health services was a positive theme noted in our focus group discussions. "Not getting shots to prevent disease" was rated among the most important unhealthy behaviors seen in the community by survey respondents. A Pap test is a method of screening for cervical cancer recommended to be performed no more than once every three years during a routine gynecological exam.

PSA Test

	United States	Arizona	Maricopa County
2016	39.5%	40.6%	52.3%
2018	33.2%	34.5%	34.4%

Source: https://www.cdc.gov/brfss/brfssprevalence/, https://www.maricopa.gov/Archive.aspx?AMID=101

Mammogram

	United States	Arizona	Maricopa County
2016	77.6%	76.2%	64.6%
2018	78.3%	73.1%	67.9%

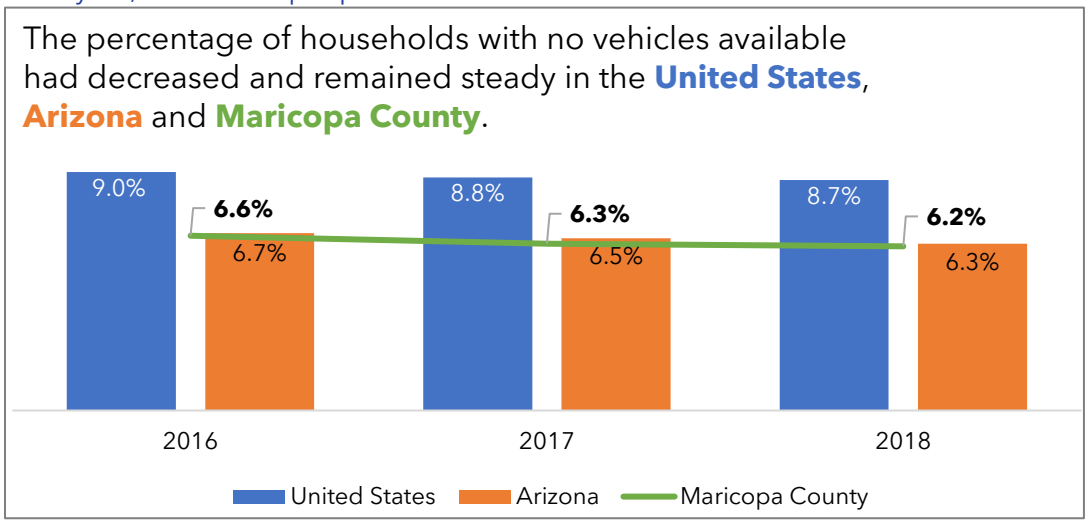
Source: https://www.cdc.gov/brfss/brfssprevalence/, https://www.maricopa.gov/Archive.aspx?AMID=101

Physical and Built Environment

Environmental interactions occur constantly, and these interactions affect quality of life, years of healthy life lived, and health disparities. Maintaining a healthy environment is central to increasing quality of life and years of healthy life. Features of the built environment like transportation and parks and recreation appear to impact human health- influencing behaviors, physical activity patterns, social networks, and access to resources.[19]

Transportation

Each year, 3.6 million people in the United States do not obtain medical care due to transportation issues. Transportation issues include lack of vehicle access, inadequate infrastructure, long distances, and lengthy times to reach needed services, transportation costs and adverse policies that affect travel. Transportation challenges affect rural and urban communities. Since transportation touches many aspects of a person's life, adequate and reliable transportation serves are fundamental to healthy communities. The lack of transportation can affect a person's access to health care services and may result in issues like missed or delayed health care appointments, increased health expenditures, and overall poorer health outcomes.[20]

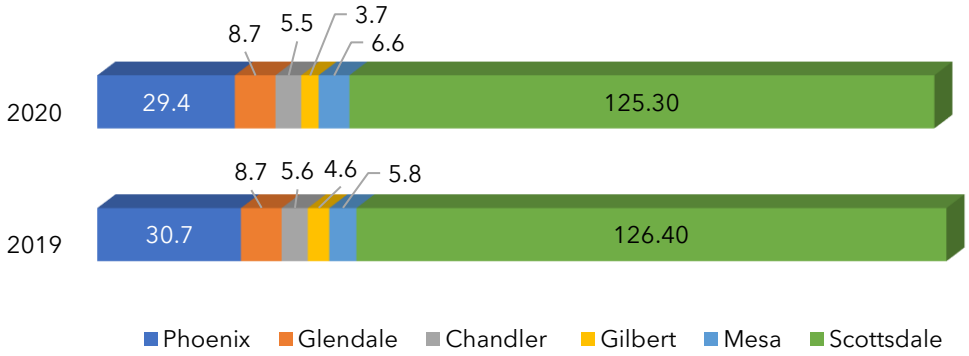


Source: https://data.census.gov/cedsci/table?g=0100000US_0400000US04_0500000US04013&d=ACS%205-Year%20Estimates%20Data%20Profiles&tid=ACSDP5Y2018.DP04

Parks and Recreation

Public park and recreation agencies create healthy communities and play a fundamental role in enhancing the physical environments in which we live. Parks and recreation foster change by helping to reduce obesity and incidence of chronic disease by providing opportunities to increase rigorous physical activity in a variety of forms, providing a connection to nature which studies demonstrate relieves stress levels, tightens interpersonal relationships and improves mental health, and fostering overall wellness and healthful habits such as becoming tobacco-free and engaging in enrichment opportunities that add balance to life. Public parks and recreation are the gateways to a healthier country, and they ensure that communities are truly livable.[2]

The acres of park land recreation access per 100,000 residents was greatest in the city of **Scottsdale** and lowest in the city of **Gilbert**.

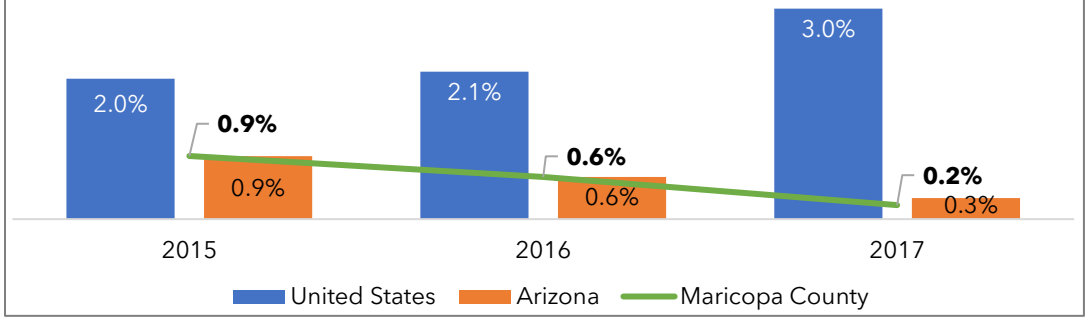


Source: https://www.tpl.org/search/site/city%20park%20facts

Lead Exposure

In many places across the United States, significant numbers of children are still exposed to lead. Children who live in households at or below the federal poverty level and those who live in housing built before 1978 are at the greatest risk of lead exposure. Additionally, children less than size years old are at an increased risk of lead exposure because their bodies are still developing, and they are growing so rapidly.[22] Exposure to lead can seriously harm a child's health, including damage to the brain and nervous system, slowed growth and development, learning and behavior

The percentage of children 5 and under with confirmed blood lead levels >=5 mg/dL had increased in the **United States**, but decreased in **Arizona** and **Maricopa County**.

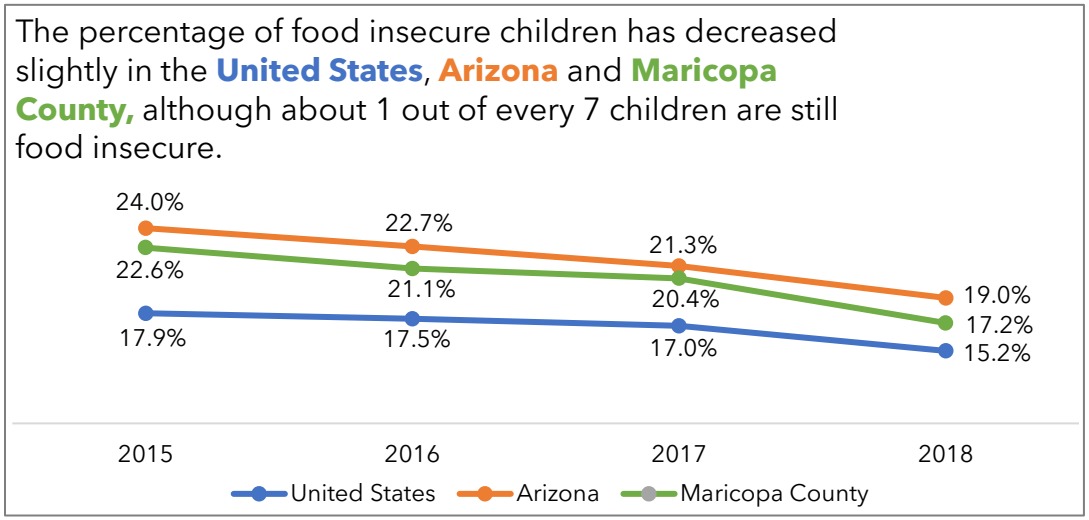


problems, and hearing and speech problems. No safe blood lead level in children has been identified.[23]

Source: https://www.cdc.gov/nceh/lead/data/national.htm, https://www.cdc.gov/nceh/lead/data/state/azdata.htm

Food Access

Feeding America describes food insecurity as a household's inability to provide enough food for every person to live an active, healthy life. Working families in the United States face innumerable situations that result to food insecurity and hunger. Currently, the United States 1 in 9 people struggle with hunger. Food insecurity creates various impacts depending on each individual including serious health complications when forced to choose between paying for food and healthcare, and a child's inability to learn and grow. Part of what makes food insecurity too difficult to solve is that underlying causes – poverty, unemployment/under-employment, and inconsistent access to enough healthy food – are often deeply interconnected. Moving in and out of food insecurity simply adds more stress to a household that may already be wrestling with instability and unpredictability.[24]

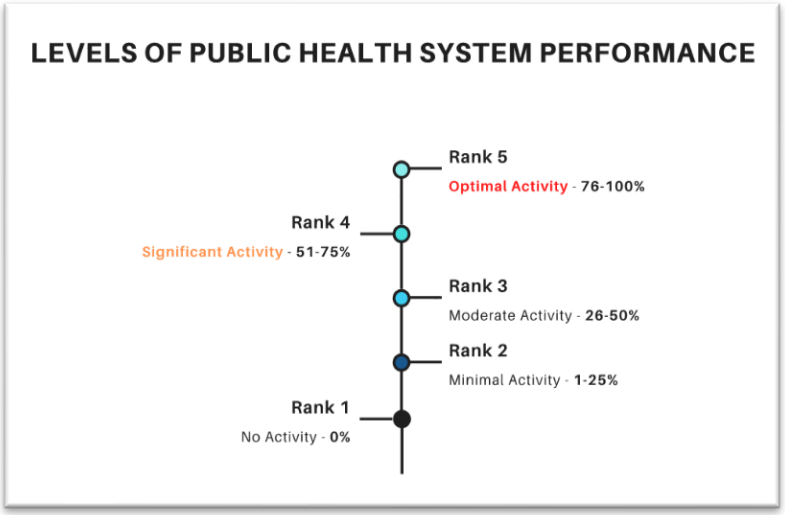


Source: https://map.feedingamerica.org/

Phase 3b – Local Public Health Assessment

How well are the 10 Essential Public Health Services being provided to the community? The Local Public Health System Assessment (LPHSA) examines the organized systems and resources that support public health and measures how well they function. The local health system is the primary focus of the assessment which is based on the National Public Health Performance Standards (NPHPS). NPHPS is organized around the ten essential public health services that a local public health department is expected to provide:

1. Monitor health status to identify and solve community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate, and empower people about health issues
4. Mobilize community partnerships to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of healthcare when otherwise unavailable
8. Assure a competent public and personal healthcare workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
10. Research for new insights and innovative solutions to health problems



As described earlier in this report, the LPHSA relies on a survey-like tool used with groups of community stakeholders who meet to discuss the performance of the local public health system in each of the ten essential services. The participants rate the system's performance on a scale that indicates the level of activity occurring in each the ten services. A list of the participating organizations is provided in Appendix A.

Findings

The quantitative results above are complemented by the qualitative comments made during the group discussions and rating sessions. Key themes were identified regarding the local public health system's performance in each of the ten-essential service (ES) areas, including:

ES1. Monitor Health Status to Identify and Solve Community Health Problems

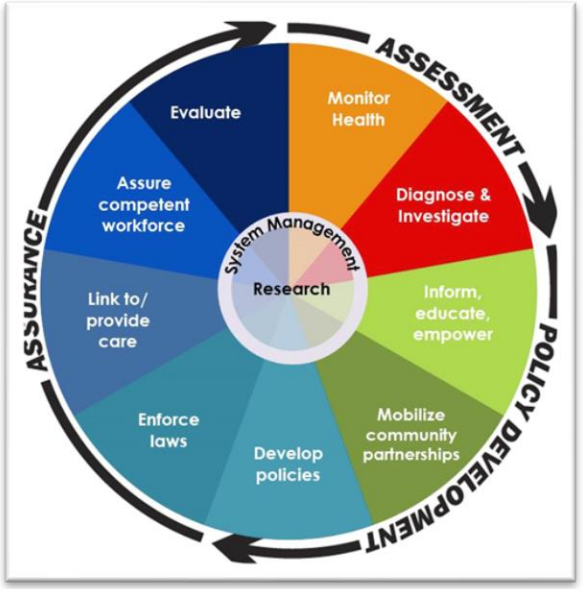
In the realm of monitoring health status, some strengths reported on this service were the ability to collect and analyze data from many sources, timely data was provided through well trained staff, and the provision of a snapshot of community health status and needs. With strengths, come weaknesses and these were captured as the ability to influence decision-makers with data, full representation of all communities, ease of access to data and information was based on the last assessment and may not reflect current or emerging needs.

ES2. Diagnose and Investigate Health Problems and Health Hazards in the Community

Participants perceived various parts of the local public health system to be efficient in having trained investigators and fully developed processes to investigate disease. However, there are perceived barriers to disease data collection as staffing limits investigations of reportable disease cases.

ES3. Inform, Educate, and Empower People about Health Issues

Communication efforts around potential public health threats and the ability to involve many individuals and partners are seen as effective. However, health education and promotion efforts are challenged by difficulty reaching individuals and partners described as target groups needed various versions of messages and channel distributions, funding complications, and message coordinating across multiple entities including government, private, and non-governmental.



ES4. Mobilize Community Partnerships and Action to Identify and Solve Health Problems

Maricopa County benefits from its partnerships and the resources partner organizations can provide, again acknowledging the HIPMC in this regard. HIPMC is widely known with diverse members and is perceived as a great model and has exceled with engaging partners and getting out there. There is still room for improvement in system-wide collaboration, both in attaining appropriate funding and engaging stakeholders to be focused on the same priorities.

ES5. Develop Policies and Plans that Support Individual and Community Health Efforts
Participants did not have feedback on strengths in this essential service, however some barriers included inadequate funding within the county to support public health community needs and challenges with coordinating plans across multiple entities.

ES6. Enforce Laws and Regulations that Protect Health and Ensure Safety
For this service, no participants provided comments to utilize as qualitative data in this assessment.

ES7. Link People to Needed Personal Health Services and Assure the Provision of Healthcare When Otherwise Unavailable
Participants perceived this resource as very important however there is inadequate funding to hire the appropriate amount of people for this program to thrive. This system is not fully developed or coordinated across all stakeholder engaged in these efforts.

ES8. Assure Competent Public and Personal Healthcare Workforce
The public health workforce in Maricopa County are all seasoned and experts in their field, however staff numbers for the size of the county are still low. Some partnering at the program level are identified. Coordination of these efforts across a diverse set of stakeholders is challenging and the limited staff results in decreased availability to participate in leadership and policy level activities including collaborative and partnership activities that influence system level efficiencies.

ES9. Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services
The system is effective in assessing and engaging with the community to develop the assessment and implementation plan. The involvement of large variety of data and partners is perceived as a great strength. There are some inconsistencies with receiving data from healthcare (acute care) systems in that they are not interconnected with public health. This service needs many evaluators/epis to collect, track and report on a wide variety of data from many partners and sources.

ES10. Research for New Insights and Innovative Solutions to Health Problems
For this service, no participants provided comments to utilize as qualitative data in this assessment.

Phase 3c – Community Themes and Strengths Assessment

What is important to the community? And how can we build upon existing assets? The Community Themes and Strengths Assessment (CTSA) provides important community context to the CCHNA. The CTSA gathers input directly from community residents, with special attention to including traditionally underrepresented groups.

While statistical data, like that from the CHSA, can give us facts and figures about health conditions in our community, the CTSA adds more meaning and significance to those facts by asking community members directly about what health issues are most important to them and what impact they see these having on their quality of life. The CTSA is an important source of "ground truth" based on input from community residents regarding their perceptions of the issues and their priorities for addressing them

The primary source of information intended to support the CTSA were our widely distributed community surveys and our more narrowly targeted focus groups with underserved populations. Some questions discussed in interviews with key informants also touched on similar topics, and the SWOT analysis with the HIPMC Steering Committee identified some corresponding issues as well.

CTSA Key Themes

- Quality of life
- Community strengths and assets
- Community concerns
- Threats and opportunities
- Health care needs
- Health care choices
- Health care experiences
- Health care barriers
- Prevention strategies
- Suggestions for improvement

Qualitative analysis of the focus groups produced a list of key themes that provide a helpful rubric to categorize and integrate the input from all these sources of input for the CTSA. Highlights from these sources are organized by theme and presented on the following pages. Complete results from each source can be found in the full source-specific reports found in the Appendices.

Quality of Life

In the focus groups, participants were asked to reflect on their own current situation in terms of their health, environment, community, fulfillment of expectations, and meeting needs or desires. Participants considered what they and other people want for their lives and the extent to which they feel they have achieved fulfillment of those wants.

Quality of life is the ability to not only participate and take care of your normal everyday needs but an outlet to do things that you enjoy and to come together and learn about each other as a community.

-Focus Group Participant-

The factors most consistently highlighted as important to participants' quality of life, included social connections, sense of community, opportunities to engage with the community, access to healthcare, quality food, and other services, agency (independence, ability and opportunity to act in a given environment, basic needs (income, housing, food, transportation), and mental, emotional, and physical health.

Additional contributors to quality of life included positive outlook/attitude and peace of mind, awareness/knowledge of community resources, dignity, respect, and acceptance of different cultures, languages and abilities, cleanliness of homes, yards, streets, and the community spaces, ability to exercise (access to parks and recreation opportunities, bike lanes) and sense if safety/security. Key informants pictured an idealized "healthy community" as one that has resources, opportunities, and supports that are accessible to all.

Many of these perceptions regarding quality of life were echoed by the broader audience who responded to the community surveys. When asked about the most important factors that will improve quality of life in their neighborhood, respondents most frequently cited distracted driving, homelessness, and illegal drug use.

Community Strengths and Assets

Community strengths and assets can be viewed as resources. Some may be tangible – people, places, structures, services available or provided – and other may be intangible – social connections, social capital, neighborhood values, and trust.

Participants in the focus groups were able to identify many other strengths and resources that they valued in their communities. Regarding services, over half of the participants reported access to public libraries and community parks as one of their greatest strengths followed closely by access to parks and recreation sites. Close to half of the participants also identified access to public transportation and having their community being accepting of diverse residents and cultures as greatest strengths in their community.

Community members noted that the availability of health clinics and hospitals were important. They highlighted assets such as community activities, classes, and events (especially for youth and seniors). They also commented that they valued their local parks, mountains, bike paths, and the beauty and cleanliness of their neighborhoods.

Specific people and organizations, or types of people and organizations, were seen as community assets as well, particularly community advocates or those who help people navigate systems and those organizations that provide some sort of necessary social support or assistance. Key informants also noted that various organizations, programs, and services were important resources and a source of strength in the community.

Well, I think access. And that means access to everything that was talked about in regard to physicians, hospitals, parks, hiking, the Y. Anything…so assets and access goes with quality of health. So, if the community has all that, you will have a strong community.

-Focus Group Participant-

Community Concerns

The theme of community concerns encompasses things people would like to improve in their communities or that they feel are less than ideal. These may include unmet community needs, gaps in services, disconnections between individuals and power structures, and perceptions of threats to others' wellbeing.

The cost of quality food. So, for example, if you want a good quality head of lettuce that is like…and not full of pesticides, it's expensive to be able to buy quality food. It's cheaper just to buy something from McDonald's or Taco Bell than it is to provide wholesome food for the children.

-Focus Group Participant-

Among focus group participants, general concerns centered on a lack adequate-affordable housing and homelessness, and healthy food options including an overabundance of non-nutritious foods and no affordable healthy options. Feeling unsafe at home, in parks, bus stops, and neighborhoods, violence and theft as well as environmental concerns such as air pollution, graffiti, tobacco & marijuana smoke, misplaced garbage and water safety were highlighted as issues that eroded sense of community. Participants also worried about substance use including opioids, alcohol, and smoking.

The concerns expressed in this cycle aligned closely with the previous cycles of the need's assessment. Pertaining to health, participants expressed that mental health was a concern brought forward at a greater frequency during this period. Participants in nearly every focus group brought forward issues related to mental health including depression, suicide, and substance abuse. In addition, with many focus groups conducted among the youth population, teen pregnancy was an issue expressed in multiple groups. Younger participants also expressed a concern about sexually transmitted diseases (STD's), and prevention/education related to that topic.

Access to healthcare systems and supports was the most common concern identified by key informants. They also saw other stressors such as wages, housing stability, and governmental roles.

> *I think that if we could empower individuals in the community to become self-sufficient in terms of accessing the resources that they need; we could probably get healthier.*
>
> -Key Informant-

Threats and Opportunities for Community Health

Community health threats and opportunities are factors that may impact individuals' physical or mental wellbeing, with the potential to be positive (opportunities) or negative (threats). These factors can be related to prevention, treatment, or maintenance, and may involve individuals, structures or organizations that threaten or promote community health.

> *There are no regulations. There's so many cancerous things in your community you know. But you're unaware of them because the government doesn't tell you about it. If the government told you about it, the realizations would encourage them to put rules and regulations on it, which would cost billions of dollars…*
>
> -Focus Group Participant-

Focus groups participants were asked to share both threats and opportunities for community health, although the threats listed far outnumbered the mentions of opportunities. Some common threats were prevalence of alcohol/drugs, unmet mental health needs, lack of available resources, diabetes, and smoking/vaping. Some noted that they often felt like medications and healthy foods were expensive in their communities. Another threat was lack of information from healthcare providers and being treated poorly. Participants feared not being respected because they are on AHCCCS or because of their gender identity. Some also felt uncomfortable identifying as LGBTQ for fear of repercussion or lack of knowledge in how to treat specific issues.

Focus group participants also noted a number of inadequacies in health and nutrition education/literacy, insurance coverage, and available resources. Many even stated the lack of available and accessible healthy food and noted the abundance and affordability of greasy, fast food.

Time was a common theme regarding threats. Participants commented about long wait times for services, especially for specialty health care. Many noted that people would wait until there is an emergency to seek help. Finally, they remarked that homelessness and unemployment are viewed a threat in the community and need to be addressed.

Where your income becomes too high that you don't quality for AHCCCS you're working but then your employer wants you to pay a certain premium but the insurance that you're paying the premium for isn't worth of term it's nothing.

-Focus Group Participant-

As previously mentioned, key informants emphasized problems with access to health care systems and supports as a leading concern for the community. Limited access to other facilities and resources that relate to health, such as parks and groceries stores, were seen by key informants as a major barrier to improving the health of the community.

Among the focus groups, two common themes arose regarding opportunities. First, participants noted that knowing and having relationships with neighbors increases the opportunities for community health. People are less likely to be alone and can reach out for support in a community where the neighbors interact. Second, participants mentioned the availability of resources and organizations that do exist for different populations such as neighborhood gardens, shade in parks, Community Bridges, methadone clinics, community centers, and smoke-free housing. A common perception among key informant participants was that funding and resources are primarily allocated to treating health conditions rather than preventative care or health education and promotion- simply due to a lack of knowledge in basic public health principles. The lack of public health knowledge among legislators' and policymakers were named around the discussion of funding for public programs and education.

I think there's a good discussion about leveraging resources that organizations can't do it alone. How we partner together, and not to just say that we're you know, networking, but really truly working together where you're sharing resources and leveraging resources.

-Key Informant-

Healthcare Needs

The theme of healthcare needs refers to perceived gaps in healthcare services and unmet healthcare desires. A number of themes regarding healthcare needs arose from the focus groups.

Overall, focus group participants desired the need for doctors who are universally accepting. Participants voiced the need for doctors who are culturally competent, accepting to non-binary and transsexual clients, and who respect the client's native cultures and languages. They highlighted that when medical professionals are not accepting, participants are more likely to delay or avoid accessing care.

Focus group participants suggested that their limited access to specialists was a major need particularly due to distance and costly co-pays. Some of these specialties identified include gynecology, gerontology, and dermatology. Access to affordable dental care was a constant theme throughout the focus groups. Participants expressed that they are unable to maintain proper oral hygiene because dental insurance is separate from health insurance and dental care without insurance is inaccessible due to high cost.

> *Access to specialized health services. I can get primary care easily, things like cardiology or neurology or any kind of specialty that's not basic health services…you have to have a service for that, or your own money.*
>
> -Focus Group Participant-

> *I feel like the clinics and everything, they should be more abundant, like in my area I got nothing. There are not enough resources around me to reach out to, they're either very far away or too expensive and that is like the biggest problem that I face and a lot of people out here face.*
>
> -Focus Group Participant-

Focus group participants also wanted more local health clinics and pharmacies which would help them stay up to date on their prescription medications and avoid costly emergency room trips. They also highlighted the need for more robust insurance plans and affordable transportation methods to increase accessibility to clinics, emergency rooms, specialists, and pharmacies. Participants also felt that navigating their health insurance was challenging and wanted assistance.

Access to affordable healthy foods and desire for informational sessions regarding diabetes, sexual education, cultural humility, cooking/nutrition, and navigating the health insurance industry were needs identified by the

focus groups as well. Regarding access to affordable healthy foods, participants expressed that close in proximity to their homes was also important to consider. For the information sessions, participants emphasized the need for the provision of credible and reliable information. They expressed an interest in general support groups and felt that meeting with others and sharing experiences when it comes to facing similar situations may be beneficial.

Healthcare Choices

The theme of healthcare choices encompasses what people are currently doing for healthcare (prevention, treatment, or maintenance), places they are going, and the services being sought or accessed.

Regarding care, focus group participants noted that they get most of their healthcare through insurance with AHCCCS named most frequently followed by Medicare. Many expressed how they receive information online using various sources such as WebMD, Mayo Clinic, Google, and others. Other common sources of information included health fairs and family members. Participants often sought care from free clinics, mobile clinics, and the emergency room. Several participants used healthcare providers in other states or countries. Due to lack of affordable healthcare and inadequate insurance coverage, this pushed individuals to seek services or medications in Mexico where they were more affordable.

> *Yes, that's why I have everything brought in from Mexico. Every time my mother-in-law come, I tell her, "Bring me this…", all of the kid's medicines.*
>
> -Focus Group Participant-

> *My kids haven't been to the doctors in years, they tell me they have something wrong I'm on Google.*
>
> -Focus Group Participant-

Focus group participants highlighted their focus on diet and eating as a preventative measure while some used homeopathic treatments and/or natural remedies. Participants noted the need to be an advocate for yourself and others. They commented that they would conduct their own research or provide their own records to ensure adequate care was provided. Key informants noted that economic and financial situations (e.g. rising cost of healthcare and insurance/health plans, low wages, high childcare costs) were an ongoing limiting factor in health care access.

Healthcare Experiences

The cost of medical services was another common theme as it was a major frustration having to delay medical treatment due to financial burden associated with the procedure. Beyond medical expenses, participants also expressed their frustrations at long wait times to see a provider. Some shared wait times as along as several months to see a provider. Discrimination was also noted by participants and several individuals on AHCCCS expressed they were turned away or received low quality services due to their insurance provider. Many other participants felt their needs and concerns were ignored by healthcare providers and desired the need for more open communication.

I had to go to a Rheumatologist in order to rule out arthritis basically because I have a lot of chronic pain. So, I went to my GP and I was like 'okay I need a referral' and they scheduled me eight months into the future. It took me eight months to get into a Rheumatologist.

-Focus Group Participant-

Focus group participants told numerous stories relating to their experiences with the healthcare system. While many were positive experiences across the cycles it appeared that twice as many stories were negative as were positive based on reasons such as those listed next as healthcare barriers.

They did see him, but they were writing down- He had a strong pain in his leg, and they asked and interviewed him when he arrived, "What kind of insurance do you have?" And he said, "I'll pay." And he replied, "Wait here" and the doctor left. He said, "You know what? Go sit outside because I have other patients and they have better insurance.

-Focus Group Participant-

Key informants also noted that the rising cost of health care and insurance/health plans was a factor keeping people from doing what needed to be done to improve their health and quality of life. Participants noted that some residents will simply avoid seeking care due to this working to decrease lifespan and others may seek care by way of sacrificing other costs such as safe, reliable housing or healthy food choices.

Healthcare Barriers

The healthcare barriers theme included anything that people perceived or actually experienced as inhibiting their access to or ability to receive or benefit from healthcare services. As previously mentioned, distrust of medical providers was frequently mentioned by focus group participants as a barrier to care. Participants commented about their lack of relationship with doctors. They felt doctors lacked cultural understanding and sensitivity which included not knowing if a provider is open to LGBTW community as well as mistrust and mistreatment. They felt that communication, particularly language barriers makes it difficult to access healthcare. It's also worth reiterating that key informants also perceived that there is a lack of cultural understanding, 'To a certain extent, culture guides the way that many ethnic minority populations do health utilization, health prevention, and health prioritization. So, I do think that there's so much more that we need to do in that space.'

Focus group participants described financial limitations as a barrier to healthcare. Participants listed the costs of copays, medications, deductibles in general. Participants also noted the high cost of ambulances and insurance. Additionally, they expressed that the cost of gas or other transportation to medical appointments limited them from accessing healthcare in their community.

The cost of the co-pay and honestly, we still need to find the insurance in Arizona. So there really is not enough education out there. You could read the books for ever. I think that there should be some place where we can go.

-Focus Group Participant-

But I think, as I've gotten older, I need more than my primary care physician, and I need this and I need this., I always wonder, is that doctor going to treat me with dignity and respect? And is he okay with the fact that I'm gay? Or is this going to be an issue? When you go to a new doctor and a specialist or a surgeon for something, you always wonder.

-Focus Group Participant-

Prevention Strategies

Preventions strategies include anything people are doing to be healthy and prevent illness, injury or other physical or mental health conditions. Focus group participants identified a number of ways that they attempted to maintain or improve their health. Physical activity was noted as an important prevention strategy. Eating healthy was another prevention strategy mentioned by focus group participants. Focus group participants also noted that engaging with their communities, participations in health education classes (including sex ed) and support groups, and preventive visits to the doctor were important prevention
strategies.

At the elderly center, they take us to the mall two or three times a month, which is very good because this is good for our health. It don't get too hot and we can walk slowly and exercise.

-Focus Group Participant-

They spoke to the kids about jobs and many other things. And that's what we need. Not just, "Say no to drugs" or, "Say no to bullying." They need to elaborate on those subjects because normally the classes that we take are meant mostly for the parents.

-Focus Group Participant-

Suggestions for Improvement

Suggestions for improvement include tangible solutions or alternatives to improve individual or community health or healthcare services.

Focus group participants wished there were ways to increase education by offering classes on topics that include healthy eating, cooking, and chronic diseases (e.g. diabetes). Participants also desired community exercise classes. Having support groups for substance use, such as Narcotics and Alcoholics Anonymous were identified as a method for improving community health. Focus group participants noted that access to healthy food and access to a community garden were important. Participants expressed a desire for greater access to fruits and vegetables, and specifically identified farmers markets as a desired option in their community.

Pertaining to health care, focus group participants noted the provision of low-cost health services is important for improving community health. Some delivery ideas included having health fairs where services can be accessed for free or for low prices. Other individuals suggested using mobile health clinics to provide access to healthcare for communities with poor transportation options. The provision of low-cost dental care in these vulnerable populations was suggested as the cost of accessing the dentist can be prohibitive.

How about more community health fairs or community dental clinics we've seen some dental clinics that came out to the mission and they were volunteer dentists and they came in and like a mobile thing and they did dental care for everybody.

-Focus Group Participant-

Access to trans healthcare is really, really important because it's not covered by a lot of insurance. I don't know a lot of the specifics because I've never been able to get on insurance but just access to top surgery or breast augmentation or hormones just that needs to be improved a lot.

-Focus Group Participant-

Just like how the vulnerable populations were mentioned above, participants also frequently identified the homeless as a community in need of additional services. Participants suggested adding more shelters, providing substance use support, and offering financial support for this population especially in the summer months. Multiple groups also expressed having services tailored for the LGBTQ community. Access to transgender healthcare such as breast augmentation and hormone therapy was emphasized as important needs in their community. Several groups noted there is a need for additional training for medical professionals, policy, and other emergency personnel. Participants also suggested cleaning the environment to improve community health. Some ideas included taking steps to remove garbage from streets, remove graffiti, and clean up empty lots.

The Steering Committee members discussed the key themes and noted where opposing factors might combine to present opportunities for future work. Among these, the members acknowledged the weakness of lacking partnership between the HIPMC and private sector and recognized the opportunity this presented for broader recruitment of new HIPMC members from this sector. The members also remarked about how healthcare reform was seen as both an opportunity and threat, and thus appeared in all four quadrants of the prioritization matrix. Similarly, they noted that, while a diverse, broad, and robust membership can be a strength to the network, it can also be a weakness because in such a large group progress can get lost.

The HIPMC Steering committee members recommended that the results of this assessment be considered during the process for the selection of the priority strategic issues for the CHIP. The HIPMC Steering Committee also decided to revisit the SWOT results as part of their annual strategic planning process.

Phase 3d – Forces of Change Assessment

Additional Forces of Change

Information gathered from other stakeholders through community surveys, focus groups, and key informant interviews identified a wide variety of issues that are potential forces of change. Many of these issues were repeated across the data collection methods, and some also resonate with the themes in the SWOT analysis by the HIPMC Steering Committee. It should be noted that the questions used to elicit these responses were not presented in the strengths/ weaknesses/opportunities/threats rubric of a SWOT analysis, although thematic analysis for the CTSA clustered some results in a similar way.

Consistent Opportunities/Community Strengths

A positive sense of self-agency was a theme reflected in the community surveys and focus groups. Key informants also noted a sense of increasing personal awareness and receptive attitudes among community residents. Appreciation for recreational facilities and activities was also identified by both the focus groups and key informants. Likewise, both key informants and focus groups saw community health organizations and their programs as important positive assets to the community (presumably including many HIPMC member organizations).

Consistent Threats/Community Weaknesses

One of the most notable and consistent themes concerned various inadequacies in access to care. This theme was identified through all three methods (surveys, focus groups, key informant interviews) and was often addressed in multiple ways. Both the focus groups and key informants also expressed concern about access to healthy foods, and poor eating habits was among the most important "unhealthy behaviors" seen in the community by survey respondents. Racism, discrimination, segregation, and the disparities that result from these practices were also consistently noted. While the nature of the survey questions necessarily limited responses, a number of other themes were shared between the focus groups and key informants, including distrust of health care providers, limited opportunities for youth, and the impact of poverty and other economic challenges (e.g. the cost of health care).

Inconsistent Themes

There were also a handful of themes that recurred by appearing on both sides of the opportunities/threats divide. Some, like the availability of health care information online were intentionally noted by focus groups as having both positive and negative potential. Others, such as the perceived "lack of" versus "increasing" personal engagement in the community may reflect the different perspectives of the focus group participants (underserved residents) and the key informants (community leaders).

Phase 4 – Identifying Strategic Issues

The four MAPP assessments provide abundant information and input that can be used to inform the community health improvement plan (CHIP). Phase four of MAPP focuses on sifting through that mass of information to winnow the large number of health concerns and related factors into a small number of priority strategic issues that will serve to focus the CHIP.

Getting from Indicators to Issues

The prioritization of strategic issues plays a significant role in the transition between the findings of the Community Health Assessment (CHA) and the development of the Community Health Improvement Plan (CHIP). As previously mentioned, the Epidemiology Expert Work Group (EEWG) established 5 topic areas with over 212 indicators to be evaluated during the Community Health Status Assessment. This list of metrics also served as the starting point in our four-step strategic issue prioritization process.

Alignment of Local, State and Federal Priorities

Assessing the alignment of local priorities for public health improvement with those at the state and federal levels is not a formal part of MAPP but is a requirement of the PHAB standards for community health assessment. Prospective consideration of federal and state health improvement priorities occurred during the strategic issue identification and prioritization process in Phase 4 as described in the previous section. For the sake of consistency with the prior (2017) community health assessment, local priorities were compared to those expressed in the National Prevention Strategy at the federal level.[25] State priorities were taken from 2016-2020 State Health Improvement Plan created by the Arizona Department of Health Services.[26]

Many of the individual health indicators evaluated during the prioritization process corresponded to a number of federal and state priorities. The value of alignment was considered in the final review and selection step of the prioritization process. Ultimately, though, all the candidate issues considered in the final round of prioritization were judged to align with some existing federal and state priorities, so alignment was not a criterion in the outcome of the prioritization process. Once Maricopa County's three priority strategic issues were selected, their alignment with federal and state priorities was re-assessed retrospectively. Judging this alignment in a consistent objective manner is not possible due to the diverse ways in which these priorities have been expressed as constructs, both between the three jurisdictional levels as well as within each of them. Some are specific protective factors or avoidance of particular risk factors (e.g. tobacco free living), some are general states of health (e.g. mental and emotional well-being), some are specific health/disease conditions (e.g.

diabetes) or broad areas of health practice (e.g. oral health), and so on. This is further complicated by their varying position along the causal chain: Some are proximal risk factors (e.g. substance abuse), some are highly distal root causes (e.g. early childhood development), and others are somewhere in between.

Maricopa County Priorities

- Access to Care
- Access to Healthy Food
- Early Childhood Development

State Priorities

- Cancer
- Chronic Lower Respiratory Disease & Asthma
- Diabetes
- Healthcare-Associated Infections
- Heart Disease & Stroke
- Maternal & Child Health
- Mental Health
- Obesity
- Oral Health
- Substance Use Disorder
- Suicide
- Tobacco
- Unintentional Injury

Federal Priorities

- Tobacco Free Living
- Preventing Drug Abuse and Excessive Alcohol Use
- Healthy Eating
- Active Living
- Injury and Violence Free Living
- Reproductive and Sexual Health
- Mental and Emotional Well-Being

In light of these inconsistencies among the priority constructs, alignment was assessed through a subjective affinity diagramming process (Balanced Scorecard Institute). The affinity relationships are more easily recognizable in some cases than in others. For instance, the local priority strategic issue of access to healthy food is plainly aligned with state and federal priorities that address healthy eating and diet-influenced chronic diseases. Likewise, it is easy to see the affinity between access to care at the county level and the more specific access issues listed at the state level. However, because the priority strategic issues for Maricopa County are high-level root causes, they may have affinity with a wide range of potential downstream risk and protective factors. This led to rather inclusive affinity judgments, especially for the strategic issue of early childhood development.

While the alignment of the priorities across jurisdictional levels is admittedly subjective, it would be a misinterpretation to suggest that this subjectivity indicates that the Maricopa County priority strategic issues lack alignment with state and national priorities. When viewed from the right, beginning with the Maricopa County priority strategic issues, the overlapping character of the affinities is suggestive of root causes. The very nature of the root causes concept suggests that our local priority strategic issues (e.g. access to healthy food) encompass the health behavior-based risk and protective factors in the state and federal priorities (e.g. healthy eating, active living), and these in-turn encompass many of the general health states and specific diseases found at those levels (e.g. diabetes, heart disease).

There is an additional aspect of alignment of community health improvement priorities that arises from the unique collaborative partnership arrangements in Maricopa County. That is the alignment of priorities among the Synapse partner hospitals and health clinics, and between these partners and the HIPMC. As shown in the table below, Synapse partner priorities vary widely, but already show some degree of alignment, particularly around access to care and prevention /treatment/management of chronic diseases and their risk factors (e.g. cancer, diabetes, obesity, etc.). While the Synapse partners will always have some independent priorities based on each partner's unique needs and capabilities, the next step toward greater alignment will be for the Synapse partners to include the three priority strategic issues in their plans during their next community health improvement cycle.

Synapse Partner Priorities							
Synapse Partners	Dignity Health St. Joseph's Hospital & Medical Center	Dignity Health Chandler Medical Center & Mercy Gilbert-East Valley	Mayo Clinic	Banner Health	Phoenix Children's Hospital	Adelante Healthcare	Native Health
2019 Priority Areas							
Access to Care	**Focus areas:** Uninsured & Underinsured	**Focus areas:** Poverty & Underinsured, Oral Health, Immunizations	**X**	**Focus areas:** Affordability of care (Reducing use of ED, PCP shortages, Recruitment/Retention, Expand primary care capabilities through BMG)	**X**	**Focus area:** Affordability of Care, Oral Health, Women's Health, Immunizations	**X**
Mental/Behavioral Health	**Focus areas:** Substance Abuse, Suicide, Maternal Health, Alzheimer's Disease	**Focus areas:** Substance Abuse-including Opioids, Suicide, Community Awareness of Resources for Mental Health, Women's Mental Health		**Focus areas:** Opioid Crisis, Vaping, Substance Abuse, Mental Health Resources/Access	**X**	**Focus areas:** Smoking, Alcohol consumption, Depression, Anxiety	**Focus areas:** Mental Health, Substance Abuse, Psychiatrics Care, Domestic Violence, Anger Management
Cancer	**Focus areas:** Colorectal, Lung, Uterine & Breast Cancer	**Focus area:** Breast Cancer	**Focus areas**: Cancer/Breast Cancer				
Injury Prevention	**Focus areas:** Falls, Unintentional Injuries, Violence	**Focus areas:** Car Safety, Falls, Trauma Prevention			**X**		

	Prevention including Human Trafficking						
Overweight/Obesity	**Focus areas:** Cardiovascular Disease, Diabetes, Chronic Conditions including Diet Related Illness						
Social Determinants of Health	**Focus areas:** Homelessness-including Housing, Food Insecurity, Problems related to Psychosocial Circumstances, Transportation	**Focus areas:** Homelessness, Food Insecurity, Transportation	**Focus Area:** Homelessness				**Focus areas:** Food Insecurity, Transportation
Chronic Disease				**Focus areas:** Cancer, Diabetes, Heart Disease, Obesity	**Focus areas:** Diabetes, Cardiovascular Disease, Asthma		**X**

Phase 5 & 6 – Next Steps

Community Health Improvement

The completion of the CCHNA is significant achievement, and while we pause to celebrate, we know there is little time to rest. With the CCHNA in hand, we now begin to plot our courses to them with care.

Phase 5 – Formulating Goals and Strategies

Deciding which route to follow means committing to specific waypoints as objectives and choosing the most appropriate means to reach those objectives. In the fifth phase of MAPP, the HIPMC will use information about our community from the CCHNA to initiate the development of a community health improvement plan, or CHIP. The CHIP begins with the creation of goal statements that, if accomplished, would make substantial strides in addressing each of the three priority strategic issues. Potential strategies for approaching each of those desired goals are also identified. The means to implement those strategies are refined in greater detail in the next and final phase.

Phase 6 – The Action Cycle

In Phase 6 of MAPP, the CHIP is drafted in detail by adding specific objectives, timelines, work plans, and assignments of responsibility for the tasks required to meet those objectives. For many members of the HIPMC, this means making explicit commitments to work collaboratively in a highly coordinated fashion to achieve a greater collective impact on one or more of the CHIP's goals.

Phase 6 encompasses the implementation of that plan and the evaluation of its outcomes over the next three years. The CHIP work plan will be implemented over a three-year period, from 2018 through 2023. Implementation of the work plan is similar to the traditional plan-do-study-act cycle for quality improvement. Although the CHIP will use a consistent framework, its work plan is not necessarily a static document. During its implementation, activities will be continually evaluated, and our results monitored so that feedback can be used to adjust and improve our course as necessary.

Although PHAB accreditation standards require a community health assessment be conducted every five years, MCDPH and its partners are committing to a three-year cycle, in part to better align with the three-year cycle of CHNAs as required by federal regulations for the Synapse member hospitals. Thus, the next CCHNA for Maricopa County will commence in 2021-22 and be completed in 2023 to support the development of the next CHIP that will be implemented in 2023 through 2026.

MARICOPA COUNTY COMMUNITY HEALTH ASSESSMENT AND IMPROVEMENT CYCLES

	Assessment Conducted	Assessment Published	CHIP Created	CHIP Published	CHIP Implemented
Previous Cycle	2016-17	2017	2017-18	2018	2018-20
Current Cycle	2019-20	2020	Ongoing 2018-23	Ongoing 2018-23	Ongoing 2018-23
Next Cycle	2021-22	2023	2023	2023	2023-26

Appendix A – HIPMC Member Agencies and Sector Representation

The member agencies of the Health Improvement Partnership of Maricopa County represent our community and its many sectors. Sector representation for each member agency are listed below.

Ability360: *disabilities, advocacy, non-profit*
Abrazo Health, West Campus: *healthcare, underserved populations*
Adelante Healthcare: *healthcare, underserved populations, Hispanic*
ADL Solutions: *business*
Aetna: *healthcare, underserved populations, Medicaid*
AllCare Health: *healthcare, insurance*
Alliance for a Healthier Generation*: schools, youth*
Alliance for Community Transformations: *non-profit, advocacy, health*
Alpha Link Marketing Communications: *business*
Alzheimer's Research and Prevention Foundation: *healthcare, seniors*
American Academy of Pediatrics Arizona Chapter: *healthcare, member organization, advocacy*
American Cancer Society Cancer Action Network: *non-profit, advocacy*
American Cancer Society: *healthcare, voluntary associations, advocacy*
American Heart Association: *healthcare, voluntary associations, advocacy*
Anthony Bates Foundation: *healthcare, advocacy*
Arizona @ Work, Maricopa County: *business*
Arizona Alliance for Community Health Centers: *healthcare, member organization, underserved populations*
Arizona Alliance for Livable Communities: *community design, member organization*
Arizona Care Network: *healthcare*
Arizona Caregiver Coalition: *non-profit, advocacy*
Arizona Center for Youth Resources: *nonprofit, education*
Arizona Coalition for Military Families: *military*
Arizona Coalition to End Sexual & Domestic Violence: *advocacy*
Arizona Community Action Association: *non-profit, advocacy*
Arizona Community Foundation: *non-profit*
Arizona Complete Health: *insurance, healthcare*
Arizona Consortium for Children with Chronic Illness: *non-profit, association*
Arizona Dental Foundation & Clinic: *non-profit*
Arizona Department of Education: *government, schools*
Arizona Department of Health Services: *government, public health*
Arizona Department of Transportation: *government, public health*
Arizona Division of Problem Gambling: *government, public health*
Arizona Family Health Partnership: *non-profit, healthcare, advocacy*
Arizona Forward: *non-profit*

Arizona Health and Physical Education: *non-profit, youth*

Arizona Healthy Aging (A-HA): *government, public health*

Arizona Hemophilia Association: *non-profit*

Arizona Hospital and Healthcare Association *healthcare, member organization*

Arizona in ACTION*: advocacy, health*

Arizona Living Well Institute*: health*

Arizona Multibank: *business*

Arizona Oncology: *health*

Arizona Partnership for Healthy Communities: *health*

Arizona Public Health Association*: public health, advocacy, member organization*

Arizona Smokers' Helpline: *health*

Arizona State Hospital: *healthcare*

Arizona State University- College of Nursing & Health, College of Health Solutions, Center for Applied Behavioral Health Policy, Center for Mindfulness, Compassion & Resilience, College of Law, College of Public Service & Community Solution, Reach Institute, School of Social Work: *higher education*

Arizona State University Southwest Interdisciplinary Research Center: *higher education, health disparities, underserved populations*

Arizona Statewide IL Council: *advocacy*

Arizona Youth Partnership: *social service, healthcare*

ASHline: *healthcare*

ASHline- UA College of Public Health: *healthcare, higher education*

Association for Supportive Child Care: *youth, education*

Association of Arizona Food Banks: *non-profit, education*

Austin/Travis County Health and Human Service Department: *government, public health*

A.T Still University: *higher education*

AZ Action for Healthy Kids: *non-profit*

AZ Coalition for Healthcare Emergency: *healthcare, public health*

AZ Energy Efficient Home: *business*

Backfit Health (APS/SPS/DRPS): *healthcare*

Baltimore County Department of Health: *government, public health*

Banner Alzheimer's Institute: *healthcare*

Banner Health: *healthcare*

Banner University Medical Center- Phoenix: *healthcare*

Be a leader foundation: *non-profit, youth, education*

Black Family & Child Services: *non-profit, social service*

Blue Cross Blue Shield of Arizona: *healthcare, insurance*

Boys and Girls Club of Metro Phoenix and East Valley: *non-profit, youth, underserved populations*

Brain Body Fitness: *public health, worksites, youth*

Bridgeway Health Solutions: *healthcare, Medicaid, underserved populations*

BridgeWell Consulting LLC: *business*

Brookline College: *higher education*

Cancer Support Community Arizona: *non-profit, healthcare, advocacy*

Cancer Treatment Centers of America: *for-profit, healthcare*

Cardon Children's Medical Center: *healthcare*

Care 1st Health Plan of Arizona, Inc.: *insurance, healthcare*

Casa Center for Positive Social Change: *non-profit, behavioral health*

Central Arizona Shelter Services: *underserved population, homelessness*

Cave Creek Unified School District: *education*

CBIZ Inc. Benefits & Insurance Services: *insurance, business*

CDC Foundation: *non-profit, public health*

Celerion: *clinical research studies, pharmaceutical research*

Centers for Disease Control and Prevention: *government, public health*

Central Arizona College: *higher education*

Chandler CARE Center: *non-profit, healthcare*

Chandler Fire Department: *government, emergency service*

Children's Action Alliance: *non-profit, advocacy*

Child & Family Resources, Inc.: *non-profit, youth, families*

Children's Museum of Phoenix: *youth, business*

Christ Cares Ministries/Christ Care Clinic: *healthcare, faith-based*

Cigna: *healthcare, insurance*

Circle the City: *non-profit, homelessness, healthcare*
City of Glendale: *government*
City of Goodyear: *government*
City of Phoenix: *government*
City of Phoenix Head Start: *youth, families, education, early childhood development*
City of Phoenix Fire Department: *government, emergency service*
City of Phoenix Housing Department Hope VI: *government, housing*
City of Scottsdale: *government*
City of Surprise: *government*
City of Surprise, Neighborhood Services: *government, housing, education*
City of Tempe Human Services: *government, human services*
ckSYNERGY: *business*
Collective STEP for Youth: *youth, healthcare*
Community Alliance Consulting LLC: *business*
Community Bridges, Inc: *non-profit, behavioral health*
Community Medical Services: *healthcare*
Concilio Latino de Salud Inc.: *healthcare, Hispanic*
Conifer Health Solutions: *healthcare*
Creciendo Unidos/Growing Together: *non-profit, Hispanic, families*
Crisis Response Network: *non-profit, healthcare*
Department of Economic Security- Division of Child Support Services, Office of Community Engagement: *governmental, youth*
Desert Christian Fellowship: *faith-based*
Desert Endoscopy Center: *healthcare*
Dignity Health- Chandler Regional Medical Center, East Valley, St. Joe's: *healthcare*
Dynavax Technologies: *business, healthcare*
E-Connect, LLC: *business*
EMPACT: *behavioral health*
Epic Health Services: *healthcare*
Equality Health: *healthcare*
Esperanca: *public health, global health, environmental health, housing, non-profit*
Estrella Mountain Community College: *higher education*
Family Involvement Center: *non-profit, families*
FamilyLife Consulting: *business, families, youth*
Feeding Matters: *non-profit, families, advocacy*
Find Help PHX: *government, healthcare*
First Church UCC: *faith-based*
First Pentecostal Church Community Center: *faith-based*
First Things First: *government, early childhood development*
Flanagan-Hyde Associates LLC: *business*
Flood Control District of Maricopa County: *government*
FrameShift Group: *business, healthcare*
Fry's Food: *business*
Gila County: *government*
Gila River Healthcare: *healthcare*
Glendale Community College*: higher education*
Grand Canyon University: *higher education*
Greater Phoenix Chamber of Commerce: *government, business*
Greater Phoenix Urban League: *non-profit, underserved populations*
Hacienda Healthcare: *healthcare, non-profit, disabilities*
Harbor America: *business*
Haven Behavioral Health: *healthcare, behavioral health*
Health Care Without Harm: *healthcare, environmental health, sustainability, justice*
Health Choice: *healthcare, insurance*
Health Net Access: *healthcare, insurance*
Health Resources in Action: *healthcare, public health*
Health Services Advisory Group: *healthcare*
Health e-Options: *healthcare*
Healthways, Inc.: *healthcare, worksites, insurance*
Healthy Arizona Worksites: *public health, worksites*
Healthy LifeStars: *non-profit, youth*
Healthy Peoria: *health service*

Honor Health Desert Mission- Food Bank, Neighborhood Renewal: *non-profit, education, housing, education, emergency*
Hope Lives- Vive La Esperanza: *non-profit, behavioral health*
Human Services Campus: *non-profit, homelessness*
Humana: *for-profit, insurance*
Inter-Tribal Council of Arizona: *non-profit, healthcare, environmental health, education*
International Rescue Committee: *non-profit, healthcare, emergency service*
Issac School District: *education*
Jackson County Health & Human Services: *government, public health*
Jewish Family & Children's Services: *faith-based, healthcare*
JHB Consulting: *business*
Junior League of Phoenix: *non-profit*
K A Stanton & Associates LLC: *business*
Keogh Health Connection: *non-profit, healthcare*
KJZZ Radio Station: *business*
Kyrene School District: *education*
Latino Healthcare Forum: *non-profit, healthcare*
Laveen Elementary District: *education*
Lenartz Consulting: *business*
Lifewell Behavioral Wellness: *non-profit, behavioral health*
Linda Cannon & Associates Inc: *business*
Local Initiatives Support Corporation: *non-profit, business*
Live Wellthy LLC: *business, healthcare*
Lovitt & Touche: *insurance, business*
Magellan Health Services: *healthcare, behavioral health, underserved populations*
Maricopa Community Colleges: *higher education*
Maricopa County Air Quality Department: *government, environmental health*
Maricopa County Correctional Health Services: *justice involved*
Maricopa County Department of Public Health: *public health*
Maricopa County Education Service Agency: *government, education*
Maricopa County Environmental Services: *environmental health*
Maricopa County Human Services Department: *government, human services*
Maricopa County Justice System Planning & Information: *government, justice*
Maricopa County Library District: *recreation*
Maricopa County Medical Society Alliance: *government, healthcare*
Maricopa County Office of Nutrition and Physical Activity: *government*
Maricopa County Public Health Clinic: *government, healthcare*
Maricopa County Sherriff's Office: *government, justice*
Maricopa County Head Start: *government, early childhood development, education*
Maricopa County Medical Society: *healthcare*
Maricopa Integrated Health System: *healthcare, behavioral health, underserved populations*
Maricopa County Regional School District: *education*
Marigold Consulting, LLC: *business*
Mayo Clinic: *healthcare*
Mayo Clinic Hospital: *healthcare*
Mayo Clinic/ASU Obesity Solutions: *higher education*
Medical Accessibility, LLC: *healthcare, disability*
Mental Health America: *non-profit, healthcare*
Mercy Care Plan: *healthcare, insurance, underserved populations*
Mercy Maricopa Integrated Care: *healthcare, behavioral health*
Mi Familia Vota: *non-profit, Latino*
Midwestern University: *higher education*
Mississippi State Department of Health- *government, public health*
Mission of Mercy: *healthcare, faith-based*
Mongeluzzi Consulting, LLC: *business*
Mountain Park Health Center: *healthcare*
National Association of County and City Health Officials: *public health, healthcare*
NAMI Valley of the Sun: *non-profit, education, families*
National Kidney Foundation of Arizona: *healthcare, voluntary association, advocacy*
Native American Community Health Center: *health*
Native American Connections: *healthcare, behavioral health, underserved populations, Native Americans*

Native Health: *healthcare, behavioral health, underserved populations, Native American*
Navajo County Public Health Services: *government, public health*
Neighborhood Outreach Access to Health: *healthcare*
Netsmart Technologies: *business*
Network for Public Health Law: advocacy, health
Newtown CDC: *non-profit, education*
NOAH Health Center: *healthcare*
North High School: *education*
Northern Arizona University: *higher education*
Norwegian Cruise Line: *business*
Novo Nordisk Inc.: *pharmaceutical*, *healthcare*
Nurse Family Partnership: *non-profit, healthcare*
One Small Step, Inc.: *non-profit, business*
Onward Hope, Inc.: *non-profit, youth*
Options for Southern Oregon: *non-profit, advocacy, housing, education, economic development*
Orchard Community Learning Center: *education, health*
Protecting Arizona' Family Coalition: *non-profit, advocacy*
Peoria Promotional Products: *business*
Performance Software: *business*
Phoenix Children's Center for Family Health & Safety: *families, youth*
Phoenix Children's Hospital: *healthcare, families, youth*
Phoenix College (Maricopa Community Colleges): *higher education*
Phoenix Health Plan: *healthcare, insurance*
Phoenix Public Library: *recreation*
Phoenix Union High School District: *education*
Phoenix Zoo: *business, recreation*
Pilgrim Rest Baptist Church: *faith-based*
Pima County Health Department: *government, public health*
Pinal County Public Health Services District: *government, public health*
Pinnacle Prevention: *non-profit, public health*
Planned Parenthood: *healthcare, advocacy, education*
Plexus Worldwide: *philanthropy, business*
Positive Behavioral Interventions & Supports Arizona: *education, behavioral health*
Preventive Health Consulting, LLC: *non-profit, public health*
Project Relevance: *business, health*
Protecting Arizona's Family Coalition: *non-profit, advocacy, families*
Providertech: *business, healthcare*
PureHarvests Foods Inc: *business*
Raising Special Kids: *social service, disability*
Recovery Empowerment Network: *non-profit, behavioral health*
Research Advisory Services: *business*
Reveille Foundation: *non-profit, underserved populations*
RightCare Foundation: philanthropy, advocacy, health care
Roosevelt School District: *education, underserved populations, Hispanic, African American*
Saguaro Evaluation Group LLC: *business*
Southwest Autism Research and Resource Center: *non-profit, advocacy, youth, disability*
SCAN Health Plan Arizona: *healthcare, insurance*
SciTech Institute: *non-profit, advocacy, education*
Scottsdale Training and Rehabilitation Services: *non-profit, disability*
Seniors Personal Assistance Corporation: *non-profit*
Serenity Hospice & Palliative Care: *healthcare, families*
Shepherd of the Hills Lutheran Church: *faith-based*
SIRC Office of Evaluation and Partner Contracts: *higher education, health*
Sojourner Center: *advocacy, education, research*
Solutions for Life Naturally LLC: *healthcare*
Somali American United Council: *non-profit*
Sonoran Prevention Works: *advocacy, health*
South Phoenix Healthy Start: *social service*
Southern New Hampshire University: *higher education*
Southwest Behavioral & Health Services: *healthcare, behavioral health*
Southwest Center for HIV/AIDS: *non-profit, advocacy, GLBTQ*
Southwest Human Development: *non-profit, youth, families*
Spaces of Opportunity: *community business, health, nutrition*
Salt River Project: *business*
St. Mary's Food Bank: *non-profit*
St. Vincent de Paul Medical & Dental Clinic: *healthcare, non-profit, families, homelessness*
Sun Health: *non-profit, healthcare*
Tanner Community Development Corporation: *faith-based, African American, non-profit*

Team Select Home Care: *healthcare*
Terros Health/LGBTQ Consortium: *non-profit, advocacy, GLBTQ*
Area Agency on Aging, Region One: *social service, disability*
Arizona Council of Human Services: *non-profit, advocacy*
The Arizona Partnership for Immunization: *healthcare, member organization, advocacy*
The Arizona Republic: *business*
The Arizona Spinal Cord Injury Association: *non-profit, healthcare*
The Centers for Habilitation: *healthcare, disability*
The Crossroads, Inc.: *non-profit, healthcare*
The University of Arizona: *higher education*
TigerMountain Foundation: *non-profit*
Touchstone Behavioral Health: *behavioral health, advocacy, non-profit*
Touchstone Health Services: *healthcare*
Town of Gila Bend: *government, rural*
Trans Queer Pueblo: *non-profit, advocacy, GLBTQ*
Transplant First Academy: *healthcare*
Trellis: *non-profit*
TruNorth Consulting: *business*
UnitedHealth Group: *for-profit, healthcare, business*
Unified in Hope: *disability, families, youth, non-profit*
United Healthcare: *healthcare, insurance*
United Way: *non-profit*
United Health Care Community Plan: *healthcare, insurance*
University of Arizona College of Medicine- Phoenix: *higher education*
University of Arizona Cooperative Extension: *higher education*
University of Arizona Mel and Enid Zuckerman College of Public Health: *higher education*
University of Arizona Nutrition Network: *higher education*
University of Minnesota: *higher education*
University of Phoenix: *higher education*
Unlimited Potential, Inc.: *non-profit, underserved population, Hispanic*
Valle de Sol, Phoenix: *non-profit, underserved population, Hispanic, behavioral health*
Valley Leadership: *non-profit*
Valley Metro: *government, transportation*
Valley of the Sun United Way: *philanthropy*
Valley of the Sun YMCA: *non-profit, youth development, healthy living*
Value our Veterans, Inc.: *non-profit*
Vitalyst Health Foundation: *philanthropy, healthcare, public health*
Walgreens: *healthcare*
Wellcare: *healthcare, insurance*
Wesley Community & Health Center: *behavioral health, healthcare, public health, underserved populations*
West Point Optical Group/Pearle Vision: *healthcare*
Western Governors University: *higher education*
WIC: *government, education, nutrition*
Wilson Elementary: *education*
Zions Bank: *business*

Appendices B through F- Community Health Assessment Reports

The following Appendices referenced in this report are subject to independent revision from time to time. For this and other reasons, they are maintained as separate documents and are available in an electronic format only. Each of these reports can be found online at: www.HIPMC.org OR www.WeArePublicHealth.org.

- **Appendix B –** Maricopa County 2019 CCHNA Community Health Status Report
- **Appendix C –** Maricopa County 2019 CCHNA Local Public Health System Assessment Report
- **Appendix D –** Maricopa County 2019 CCHNA Community Health Surveys Report
- **Appendix E –** Maricopa County 2019 CCHNA Focus Groups Report
- **Appendix F –** Maricopa County 2019 CCHNA Key Informant Interviews Report

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This report was written by staff of the **Maricopa County Department of Public Health** on behalf of the **Health Improvement Partnership of Maricopa County** and the **Synapse Coalition of Maricopa County**. The contents do not necessarily represent the official position of or endorsement by the individual member agencies of these groups.

Suggested reference:

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